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User Manual Verson 3.3

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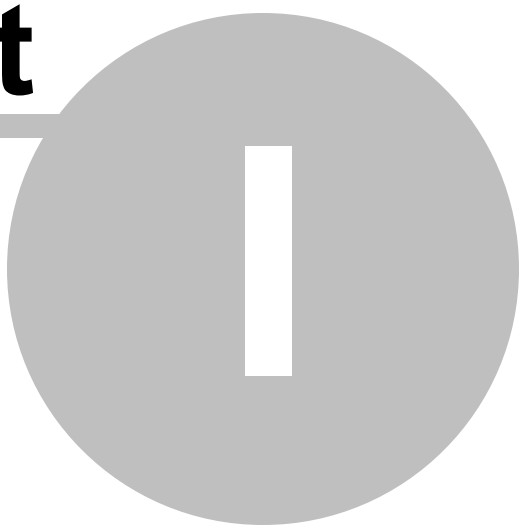
Part



1 IQCare - Overview

IQCare is Open Source software. The source code, deployment executables, installation guides and training guides can be downloaded from http://fgiqcare.codeplex.com/. This work is licensed under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 Unported License. To view a copy of this license, visit http://creativecommons.org/licenses/by-nc-sa/3.0/ or send a letter to Creative Commons, 444 Castro Street, Suite 900, Mountain View, California, 94041, USA.

IQCare has two major components that make up the entire application of IQCare

1) IQCare (browser based data entry application)
   - IQCare application configuration
   - HIV Care Data entry
   - Pre-defined reports and custom reports
2) IQCare Management (Windows based form configuration)
   - Form builder technical areas, fields and forms

Both parts of the IQCare make up a comprehensive application that is used for managing patients and collecting clean and accurate data for further analysis and program improvement.

For more information about installation and trouble shooting see Installations Guides.

If you would like a hardcopy of this IQCare User Guide, please send email to IQSupport@futuresgroup.com

1.1 IQCare Capabilities

IQCare was initially designed for the international HIV patient care community and has grown into a fully functional HIMS system supporting HIV, TB, PMTCT and other health care areas. New features continue to be specified directly by the Local Partners and Strategic Information Advisors in the field, creating a high value system.

IQCare for HIV Care capabilities include:

- A robust underlying database which is excellent for reporting
- Business rule driven clinical forms with data validation
- Patient appointment scheduling

- HIV Care Static form set, MOH Static form set (MOH HIV Care card) and Smart ART dynamic forms (created in using IQCare Management form builder)
- A variety of patient, facility and donor reports as well as a flexible custom reports module
- Customizable lists that display within the forms
- Custom fields that can be added to static forms
- Form builder to build your own forms associated with new program/technical areas
- Fine grain user access features that manages the areas a user can or can not access within the application.
- The ability to deploy IQCare as a stand alone application or as a LAN application

IQCare for PMTCT capabilities include:

- Flexible form builder for country specific PMTCT registers
- Comprehensive patient population dashboard
- Country MOH reports
- Custom reports

1.2 Glossary and Definition of Terms

Term/Acronym	Description
AIDSRelief Project	A US consortium of partners to support antiretroviral therapy (www.aidsrelief.org) including these members:CRS, IMA, CMMB, IHV, FG
CDC	Center for Disease Control
CMMB	Catholic Medical Mission Board
CRS	Catholic Relief Services
CTC, CTC1, CTC2, CTC3	CTC stands for Care and Treatment Clinic The CTC set of forms are from the Tanzanian -- National HIV Care and Treatment Programme ○ CTC1 is the patient-held ID card that has some key data and next appoint information ○ CTC2 is the patient record form which is displayed in a register format.; ○ CTC3 are the monthly reports required by the Tanzanian MoH
CTCT	In field technical coordinating team for each country (Country Technical Coordinating Team)
FG	Futures Group Responsible for strategic information initiatives and reporting
HRSA	Health Resources and Services Administration
IHV	Institute of Human Virology (University of Maryland) Responsible for lab and clinical training
IMA	Interchurch Medical Assistance Responsible for procurement and distribution of ARVs
IQCare	International Quality Care
HIV Care Static Forms	The set of static forms used by AIDSRelief and other programs.

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LPTF	Local Patient Treatment Facility
M&E	Monitor and Evaluation
MOH	Ministry of Health (one in each country)
NACP	National Care and Treatment Programme
OGAC	Office of the Global AIDS Coordinator
POS	Points of Service
PMTCT	Preventing Mother-To-Child Transmission
QAQI	Quality Assurance, Quality Improvement
USG	United States Government
Forms	
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BD	Twice a day (bi-daily)
1BD	One tablet, twice a day
CHV	Community Health Volunteer
CHW	Community Health Worker
DOT	Directly Observed Therapy
DS	Double Strength
Dynamic Form	Form created in form builder where the fields and formatting configured in IQCare Management is displayed and available for use in the IQCare data entry user interface.
FDC	Fixed Dose Combination
LMP	Last Menstrual Period
LPTF	Local Patient Treatment Facility
OD	Once a day
1OD	One tablet, once a day
OI	Opportunistic Infection
Static Form	A form that has been developed so that the fields and formatting can not be changed in IQCare Management.
SS	Single Strength

1.3 Installation Guides

IQCare Installation Reference Files

There are a number of reference documents that can guide you through the set up and troubleshooting of components that are required to run IQCare.

- IQCare installation guide for standalone machines and server (Feb 2009)

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- Setting up IQCare in a LAN (networked) environment (Oct 2007)
- IQCare Installation Troubleshooting (Oct 2007)
- SQL Express Administration (Oct 2007)

1.4 Technical Support

Technical Support
If you need technical help, you have found a defect or you would like an enhancement, please contact your Futures Group, IQCare representative and they will help resolve your issues or relay your request.

You can also send your questions to the support email address: IQSupport@futuresgroup.com

1.5 IQCare Service

- IQCare Service

  The IQCare Service is a special application component that allows the IQCare database to be on a separate server from the IQCare application, if needed. This service must be running in order for IQCare to run properly.

  Accessing the service via the IQCare Service dialog
  The IQCare service can be stopped and started using the IQCare Service dialog. This dialog can be accessed from your All Programs button and the link can be found at the top of the list of programs. You may also find the IQCare icon in your Toolbar tray at the bottom of your screen.

  Accessing the service via the control panel
  You can also stop and start the IQCare Service from the Control Panel. To access the service in this way follow the links:
  Control Panel -> Administrative Tools -> Services -> IQCare Service

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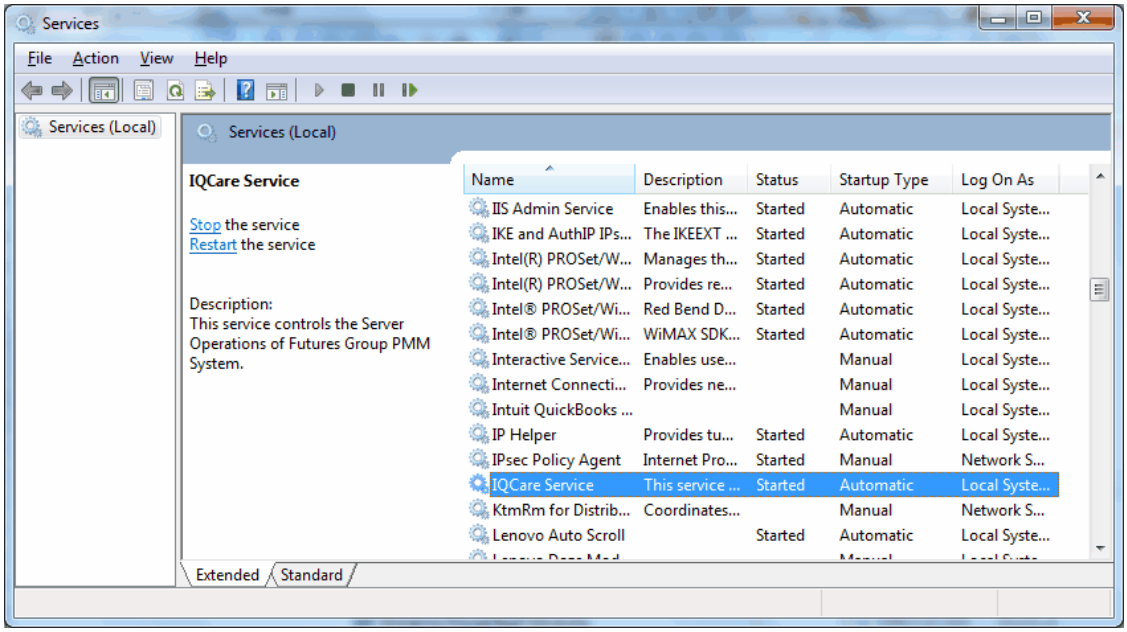
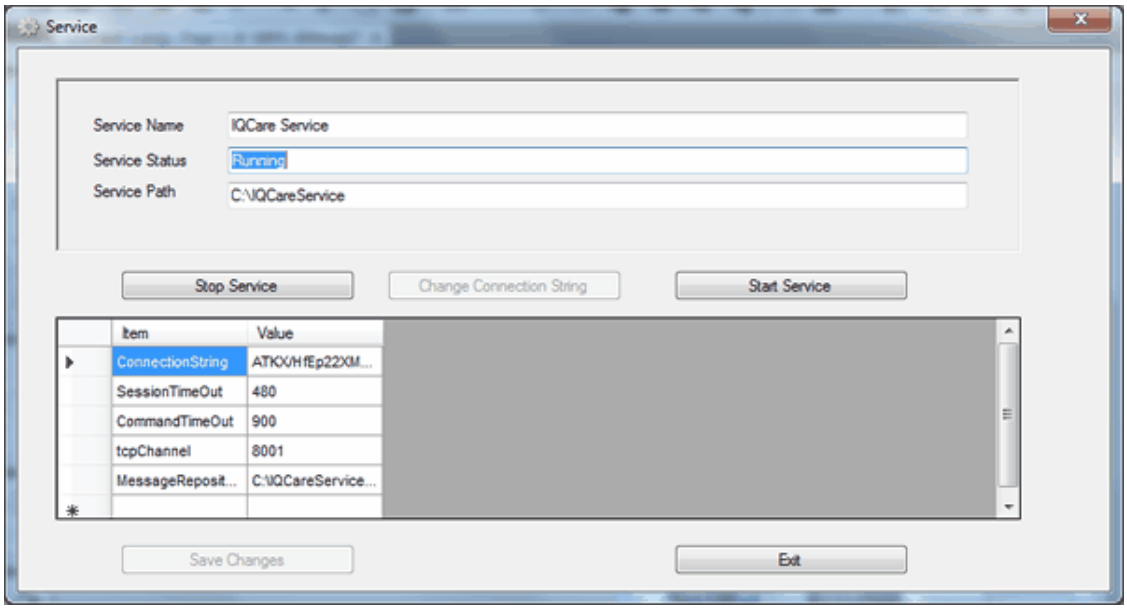

Services
File Action View Help
Services (Local)
Services (Local)
IQCare Service
Stop the service
Restart the service
Description:
This service controls the Server Operations of Futures Group PMM System.
Name Description Status Startup Type Log On As
IIS Admin Service Enables this... Started Automatic Local Syste...
IKE and AuthIP IPs... The IKEEXT ... Started Automatic Local Syste...
Intel(R) PROSet/W... Manages th... Started Automatic Local Syste...
Intel(R) PROSet/W... Provides re... Started Automatic Local Syste...
Intel® PROSet/Wi... Red Bend D... Started Automatic Local Syste...
Intel® PROSet/Wi... WiMAX SDK... Started Automatic Local Syste...
Interactive Service... Enables use... Manual Local Syste...
Internet Connecti... Provides ne... Manual Local Syste...
Intuit QuickBooks ... Manual Local Syste...
IP Helper Provides tu... Started Automatic Local Syste...
IPsec Policy Agent Internet Pro... Started Manual Network S...
IQCare Service This service ... Started Automatic Local Syste...
KtmRm for Distrib... Coordinates... Manual Network S...
Lenovo Auto Scroll Started Automatic Local Syste...
Extended Standard

- Connection String

  A connection string is special text that specifies information about a data source (in this case, the IQCare database) and the means of connecting to it. It is passed in code to the IQCare Service in order to initiate the connection between the IQCare database and the IQCare applications. Sometimes this connection string needs to be changed.

  To change the connection string
  1. Click Stop Service to stop the service
  2. Click Change Connection String



  3. Enter the information about the database connection

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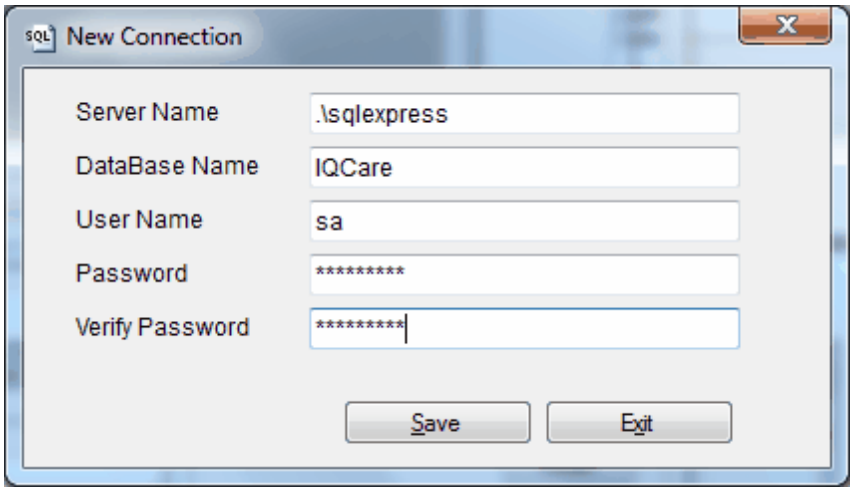
4. Click Save



5. Click Start Service to restart the service

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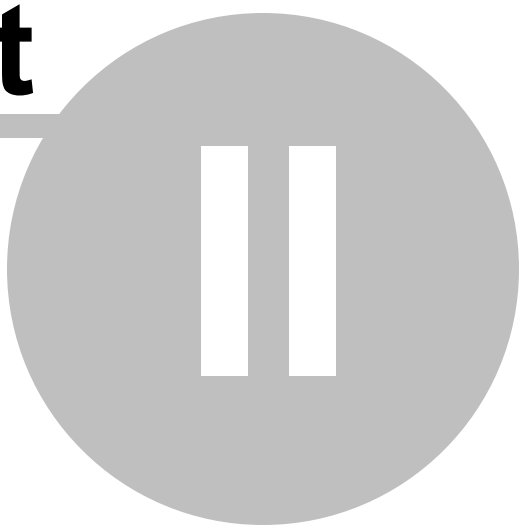
Part



2 International Standards

IQCare follows two international standards -Health Level Seven (HL7) and International Classification of Diseases, Tenth Revision (ICD10).

HL7 Implementation in IQCare

The Health Level Seven (HL7) organization is an all-volunteer, non-profit organization involved in development of international healthcare informatics interoperability standards. The HL7 standard specifies a number of messaging standards, guidelines, and methodologies by which various healthcare systems can communicate with each other. As such, IQCare creates an HL7 message file that can be imported by another software application that also has been configured to understand these standard messages.The HL7 patient message file is generated on a per-patient basis. IQCare is using the V3 format for the HL7 messaging standard. For more information please see http://www.hl7.org

To Generate an HL7 patient message file for transferring patient data

1. Search for a patient
2. From the patient navigation, select Patient Reports/Blue Card
3. The HL7 message file is generated at the same time as the Blue Card Excel report is created. This file is located at c:\inetpub\wwwroot\iqcare\hl7message directory. As this file does not have an extension, to view the file open it with Notepad.

HL7 V3 XML file generated by IQCare which is processed by the Mirth Gateway

```
<?xml version="1.0" encoding="utf-8" standalone="no"?>
<!-- edited with XMLSPY v2004 rel. 3 U (http://www.xmlspy.com) by Gregg Seppala (HL7 Publications TC) -->
<!-- XML Example for January 2006 Ballot Patient Administration storyboard 2.1.1.1 Add New Person
(http://www.hl7.org/v3ballot/html/domains/pa/amprpa_Person.htm#PRPA_ST101001-str)-->
<!-- New Person Added notification interaction sent after Nancy Nuclear is added to the Good Health Organization Person Registry-->
<!-- Transmission wrapper included for completeness only; RoseTree autogenerated values have not been edited -->
<!-- Example copyright 2005 by Health Level Seven, Inc. -->
<Message xmlns="urn:hl7-org:v3" xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance" >
  <id root="2.16.840.1.113883.19.3.2409" extension="1-976-245" displayable="true"/>
  <creationTime value="200202111143035.1600-06"/>
  <securityText>The string.</securityText>
  <versionCode code="CS-CODE"/>
  <interactionId root="2.16.840.1.113883.19.3.2409" extension="1-976-245" displayable="true"/>
  <profileId root="2.16.840.1.113883.19.3.2409" extension="1-976-245" displayable="true"/>
  <processingCode code="CS-CODE"/>
  <processingModeCode code="CS-CODE"/>
  <acceptAckCode code="CS-CODE"/>
  <sequenceNumber value="123"/>
  <attachmentText mediaType="text/plain">This is a brief note.</attachmentText>
  <attentionLine>
    <keyWordText/>
    <value xsi:type="AD|BL|CD|CE|CV|ED|EN|GTS|II|INT|MO|ON|PN|PQ|REAL|RTO|ST|TEL|TN|TS" nullFlavor="NI"/>
  </attentionLine>
  <ControlActProcess>
    <id root="2.16.840.1.113883.19.3.2409" extension="1-976-245-000" displayable="true"/>
    <code code="PRPA_IE101001" codeSystem="2.16.840.1.113883.5.4" codeSystemName="ActCode">
      <originalText>Person Event Activate Notification</originalText>
    </code>
    <effectiveTime>
      <high value="200208081400" inclusive="true"/>
    </effectiveTime>
    <priorityCode code="R" codeSystem="2.16.840.1.113883.5.7" codeSystemName="ActPriority" displayName="routine"/>
    <author>
      <contextControlCode code="AP"/>
      <time>
        <low value="200208081350" inclusive="true"/>
```

HL7 V3 XML file example as processed through the Mirth Gateway

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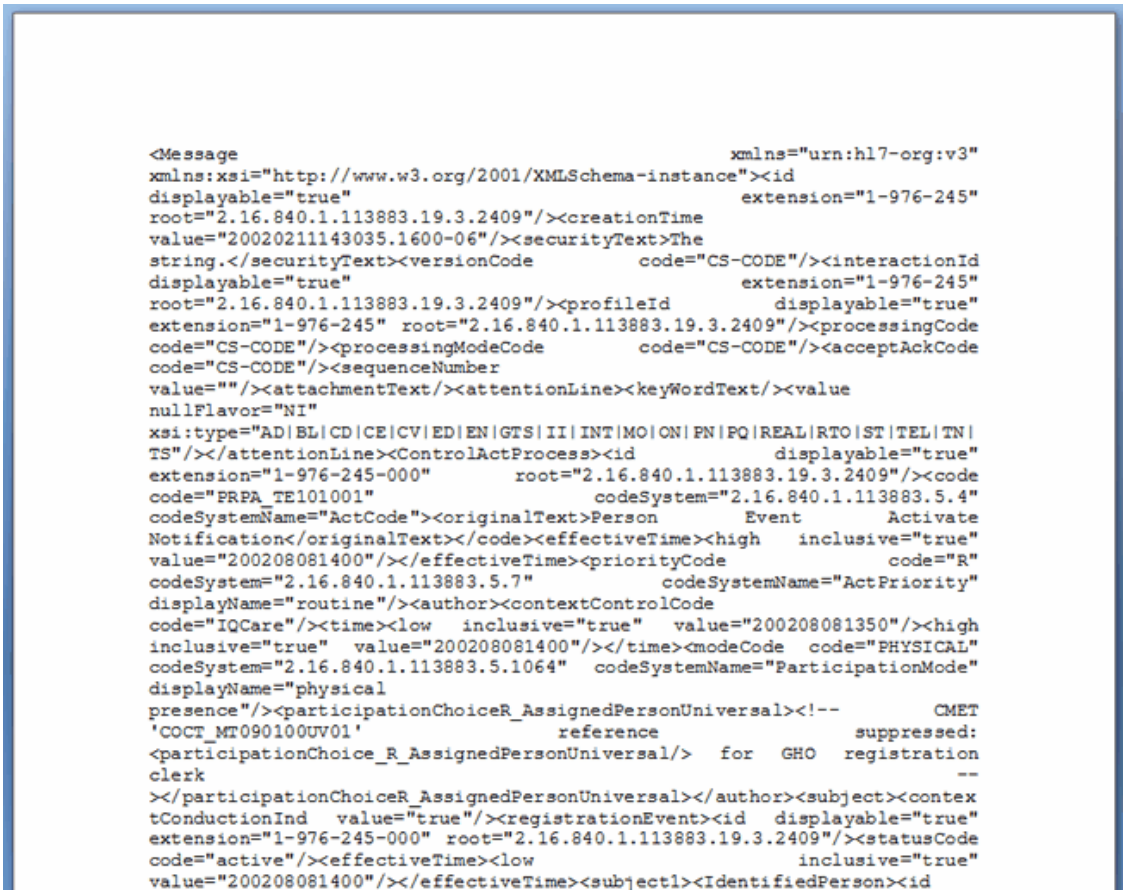


```
<Message                                              xmlns="urn:hl7-org:v3"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"><id
displayable="true"                                    extension="1-976-245"
root="2.16.840.1.113883.19.3.2409"/><creationTime
value="20020211143035.1600-06"/><securityText>The
string.</securityText><versionCode          code="CS-CODE"/><interactionId
displayable="true"                                    extension="1-976-245"
root="2.16.840.1.113883.19.3.2409"/><profileId          displayable="true"
extension="1-976-245" root="2.16.840.1.113883.19.3.2409"/><processingCode
code="CS-CODE"/><processingModeCode         code="CS-CODE"/><acceptAckCode
code="CS-CODE"/><sequenceNumber
value=""/><attachmentText/><attentionLine><keyWordText/><value
nullFlavor="NI"
xsi:type="AD|BL|CD|CE|CV|ED|EN|GTS|II|INT|MO|ON|PN|PQ|REAL|RTO|ST|TEL|TN|
TS"/></attentionLine><ControlActProcess><id             displayable="true"
extension="1-976-245-000"       root="2.16.840.1.113883.19.3.2409"/><code
code="PRPA_TE101001"                  codeSystem="2.16.840.1.113883.5.4"
codeSystemName="ActCode"><originalText>Person       Event       Activate
Notification</originalText></code><effectiveTime><high   inclusive="true"
value="200208081400"/></effectiveTime><priorityCode              code="R"
codeSystem="2.16.840.1.113883.5.7"          codeSystemName="ActPriority"
displayName="routine"/><author><contextControlCode
code="IQCare"/><time><low   inclusive="true"   value="200208081350"/><high
inclusive="true"   value="200208081400"/></time><modeCode  code="PHYSICAL"
codeSystem="2.16.840.1.113883.5.1064"  codeSystemName="ParticipationMode"
displayName="physical
presence"/><participationChoiceR_AssignedPersonUniversal><!--        CMET
'COCT_MT090100UV01'                 reference                suppressed:
<participationChoice_R_AssignedPersonUniversal/>  for  GHO  registration
clerk                                                              --
></participationChoiceR_AssignedPersonUniversal></author><subject><contex
tConductionInd   value="true"/><registrationEvent><id   displayable="true"
extension="1-976-245-000" root="2.16.840.1.113883.19.3.2409"/><statusCode
code="active"/><effectiveTime><low                        inclusive="true"
value="200208081400"/></effectiveTime><subject1><IdentifiedPerson><id
```


ICD10 Implementation in IQCare

The International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) is a coding of diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization. In IQCare, diseases that can be selected in the Initial Evaluation form, ART and Non-ART Follow up forms are mapped in the database to one or more diseases. Please see the mapping below.

Custom reports that display diseases will also display the ICD10 code. Please see custom report example below.

IQCare Disease Name	ICD10 Code	ICD10 Name
Pulmonary TB Smear+	A15.0	Respiratory tuberculosis,bacteriologically and histologically confirmed
Pulmonary TB Smear -	A16.0	Respiratory tuberculosis,not confirmed bacteriologically or histologically
Extrapulmonary TB	A18	Tuberculosis of other organs
PCP	B20.6	HIV disease resulting in Pneumocystis carinii pneumornia
Pneumonia	J18	Pneumonia, organism unspecified
Other Mycobacteria	A31	Infection due to other mycobacteria
Oral Candidiasis	B37.0	HIV disease resulting in candidiasis

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Esophageal Candidiasis	B37.8	HIV disease resulting in candidiasis
CMV Retinitis	B20.2	HIV disease resulting in cytomegaloviral disaese
Herpes Zoster	B02	Zoster [herpes zoster]
Herpes Simplex	B00	Herpesviral infection, unspecified
Lymphoma	B21.2	HIV disease resulting in other types of non-Hodgkin's lymphoma
Cryptococcal Meningitis	B45.1	Cerebral cryptococcosis
Encephalopathy/ Dementia	B22.0	HIV disease resulting in encephalopathy
Neuro (Toxo, PML, Lymphoma)	B58, A81.2	Toxoplasmosis, Progressive multifocal leukoencephalopathy
Chronic Diarrhoea/ Wasting	B22.2	HIV disease resulting in wasting syndrome
Salmonellosis	A02.9	Salmonella infection, unspecified
Septicemia	A41.9	Speticaemia, unspecified
KS-Cutaneous	C46.0	Kaposi's sarcoma of skin
KS-Visceral	C46.8	Kaposi's sarcoma of multiple organs
Genital Ulcerative Disease	N48.5, N76.5, N76.6	Ulcer of penis, Ulceration of vagina, Ulceration of vulva
Urethritis/Cervicitis	N34, N72	Nonspecific urethritis, Inflammatory disease of cervix uteri
PID	N73.9	Female pelvic inflammatory disease, unspecified
Liver Disease	K76.9	Liver disease, unspecified
Kidney Disease	N19	Unspecified renal failure
Anaemia	D64.9	Anaemia, unspecified
Drug/Alcohol Abuse	Z72.1, Z72.2	Alcohol use, drug use
Malaria	B54	Unspecified malaria
Immune reconstitution syndrome	Y56.0	Topical agents primarily affecting skin and mucous membrane and ophthalmological otorhinolaryngological and dental drugs adverse effect

Running Custom Reports Displaying ICD10 Disease Codes

To see the IDC10 codes associated with disease, run a custom report using the OI and AIDS Defining Illness category. Below is a simple example.

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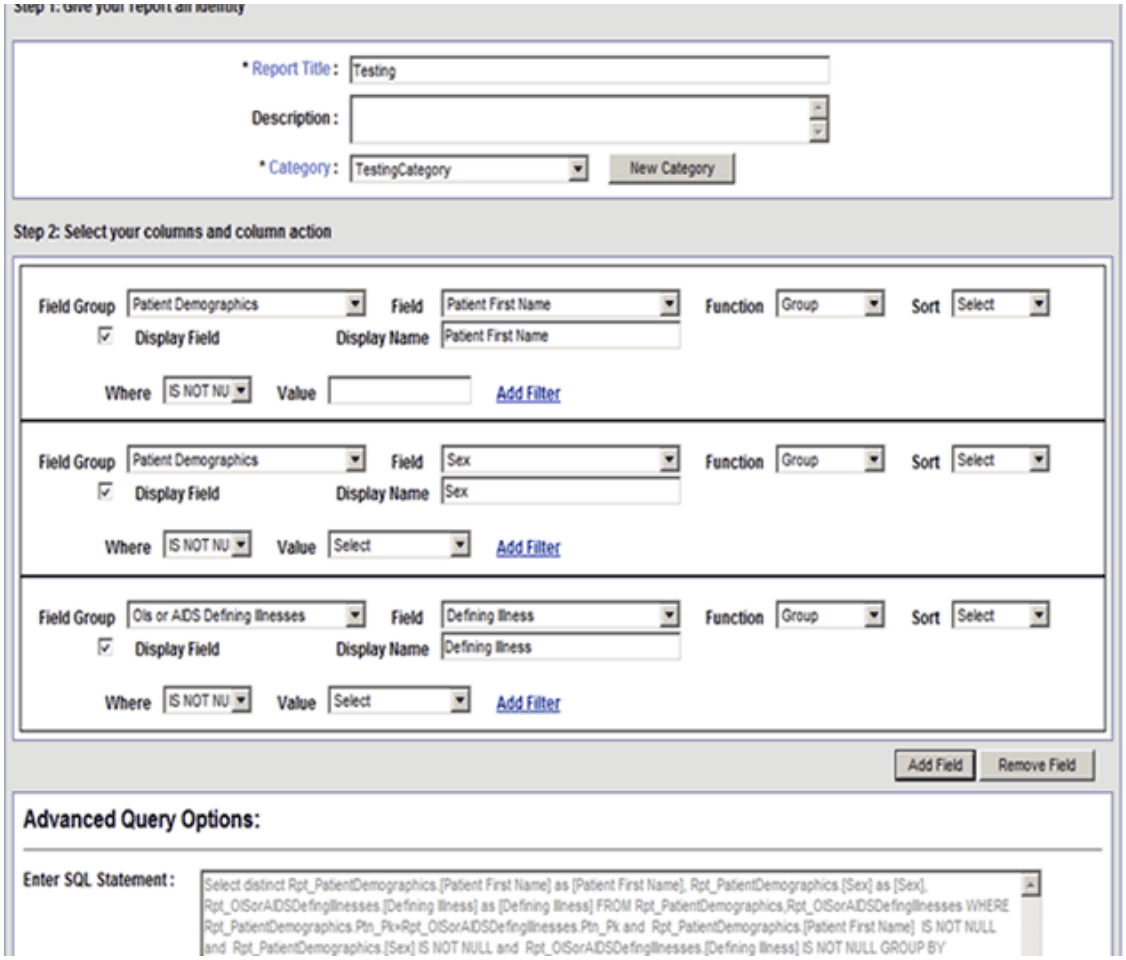
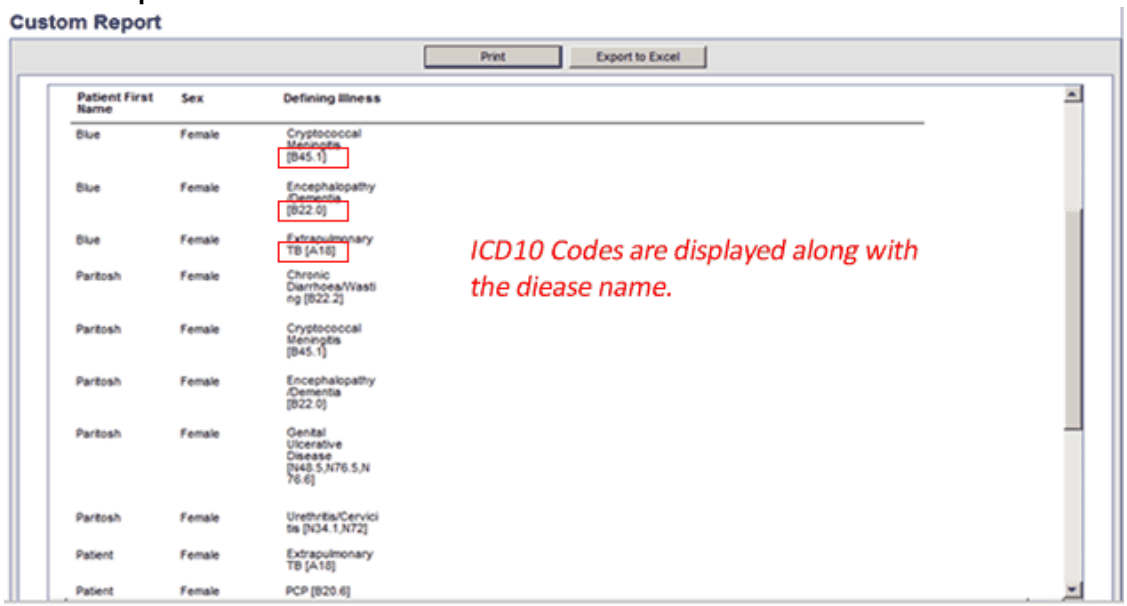

* Report Title : Testing
Description :
* Category : TestingCategory
New Category
Step 2: Select your columns and column action
Field Group Patient Demographics
Field Patient First Name
Function Group
Sort Select
Display Field
Display Name Patient First Name
Where IS NOT NU
Value
Add Filter
Field Group Patient Demographics
Field Sex
Function Group
Sort Select
Display Field
Display Name Sex
Where IS NOT NU
Value Select
Add Filter
Field Group Ois or AIDS Defining Illnesses
Field Defining Illness
Function Group
Sort Select
Display Field
Display Name Defining Illness
Where IS NOT NU
Value Select
Add Filter
Add Field
Remove Field
Advanced Query Options:
Enter SQL Statement :
Select distinct Rpt_PatientDemographics.[Patient First Name] as [Patient First Name], Rpt_PatientDemographics.[Sex] as [Sex], Rpt_OISorAIDSDefingIllnesses.[Defining Illness] as [Defining Illness] FROM Rpt_PatientDemographics,Rpt_OISorAIDSDefingIllnesses WHERE Rpt_PatientDemographics.Ptn_Pk=Rpt_OISorAIDSDefingIllnesses.Ptn_Pk and Rpt_PatientDemographics.[Patient First Name] IS NOT NULL and Rpt_PatientDemographics.[Sex] IS NOT NULL and Rpt_OISorAIDSDefingIllnesses.[Defining Illness] IS NOT NULL GROUP BY

Custom Report Results


Custom Report
Print
Export to Excel
Patient First Name
Sex
Defining Illness
Blue Female Cryptococcal Meningitis [B45.1]
Blue Female Encephalopathy /Dementia [B22.0]
Blue Female Extrapulmonary TB [A18]
Paritosh Female Chronic Diarrhoea/Wasting [B22.2]
Paritosh Female Cryptococcal Meningitis [B45.1]
Paritosh Female Encephalopathy /Dementia [B22.0]
Paritosh Female Genital Ulcerative Disease [N48.5,N76.5,N76.6]
Paritosh Female Urethritis/Cervicitis [N34.1,N72]
Patient Female Extrapulmonary TB [A18]
Patient Female PCP [B20.6]
ICD10 Codes are displayed along with the diease name.

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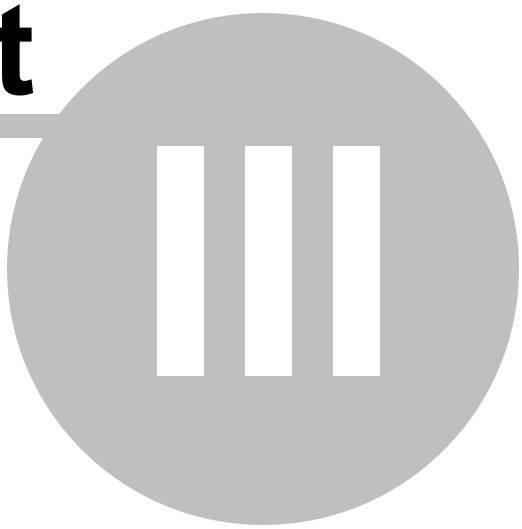
Part



3 Facility Level Features

IQCare is organized on two levels:
The Facility level (top level of navigation) and the Patient level (navigation displayed once you have established or searched for a patient.) Data entry happens mostly at the patient level. At the Facility level in addition to configuring the application with custom lists and fields, you can see information about the facility (facility home page) or run reports on the entire facility data.

This section includes:
- Login Page
- Facility Home Page
- Facility and Patient Navigation
- Find/Add Patient
- Appointment Scheduler

Other facility level features include:
- Pre-defined reports
- Custom reports

3.1 Login Page

Login Credentials
Before you can login, your IQCare administrator must set up a Username and Password for you. The areas of the application that you can navigate to are dependent on the access rights that your administrator has given to you. The navigation bar will display only those areas in the application that you have rights to enter.

Multi-attempt Lockout
The system will be locked if a User attempts to enter IQCare 3 times with an incorrect password. The system will allow the User to login after 5 minutes.

Facility/Satellite Selection
You are required to login to IQCare in order to enter patient data. In addition to the Username and Password, you must also specify the location for which you want to enter patient data. Patients not located at the clinic/satellite you have specified at login can not be accessed; you must log out and re-login to access patient data at the location they are receiving treatment.

Preferred Location Check Box
For some IQCare configurations, the list of Facility/Satellite location can be very long. A data entry clerk will only want to enter data for patients getting treatment at a handful of locations. These “preferred” locations are set in the Facility/Satellite configuration and displayed when the Preferred Location box is checked.

Login Image
The login page image can be customized through the Facility Set up page. For example, you can have a logo of your facility as the login image.

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International Quality Care
IQCare
by AIDSRelief
Patient Management and Monitoring System
10-May-2010
IQSolutions
by Futures Group
...Empowering people to make informed decisions
Login
Username
Password
Preferred Location
Facility/Satellite
Select
Login
Recommendation
IQCare is best viewed on Internet Explorer 8 or FireFox 3. Web site visitors using earlier versions of this or other browsers may encounter occasional format anomalies when viewing pages from this web site.
International Quality Care Patient Management and Monitoring System Ver2.4 Copyright © 2006 AIDSRelief. All rights reserved. Release Date: 30-Apr-2010

3.2 Facility Home Page

The Facility Home page is the initial landing page for the IQCare application after logging into the program.

The Facility Home page displays those technical area that have been "turned on" or activated in the Facility Setup page. If a technical area has been selected in the Facility Set up page then the query results will display in this page.

- Pre-defined facility home page statistics

  Three facility home page sections have been pre-defined:
  - HIV Care
  - PMTCT
  - Exposed Infants

  To see the detailed data about each of these program areas, click you the "more..." link. A new, separate browser will displays the full set of facility statistics for each program.

  Data Drill-Down
  - Blue color text with an underline indicates a link. In the facility statistics pages, these links open an Excel spreadsheet with the patient details related to the statistic.
  - Statistics are based on the logged in location. You can see the statistics for other locations by selecting different location in the Facility/Satellite select list. Or, you can see all of the statistics aggregated by selecting the “All” option.

  See Facility Home Page Business Rules for the business rules used to calculate the facility home page statistics.

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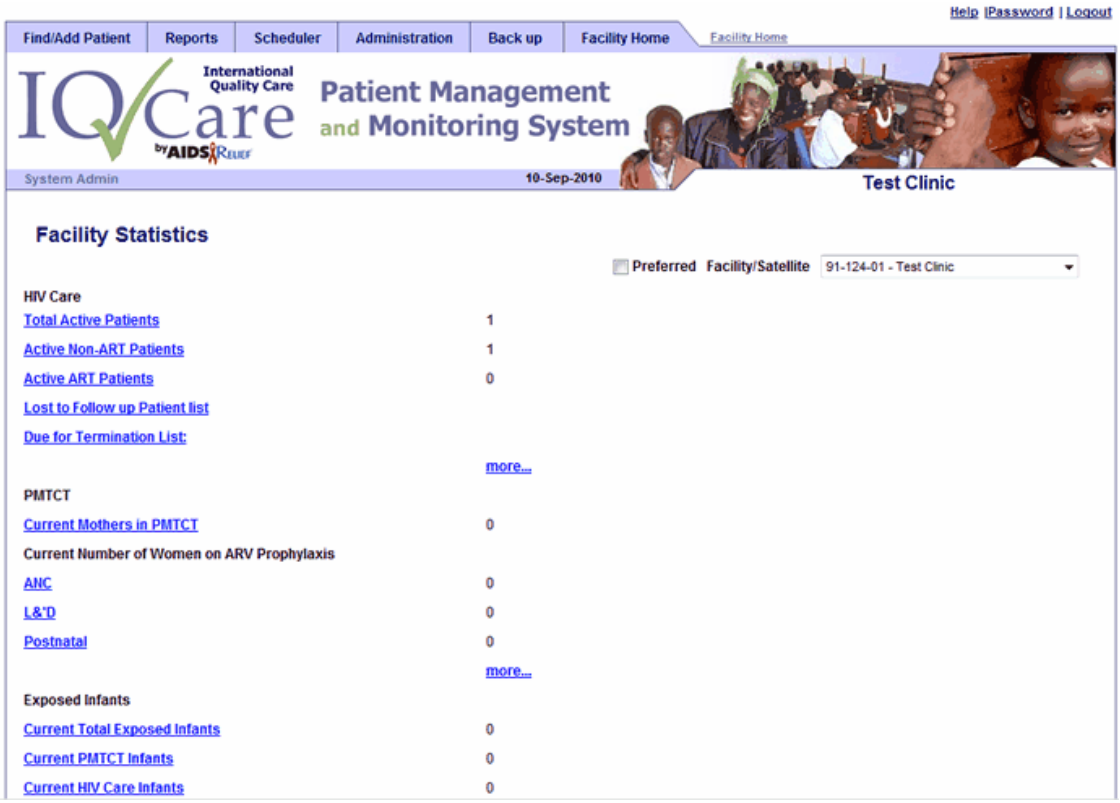

- Home page statistics for newly created technical areas

  For new technical area that you create in addition to the pre-defined one can have facility home page statistics displayed. These queries are built in IQCare management - Manage Home Pages.

3.2.1 Facility Home Page Business Rules

Last Updated: January 2010

- **HIV Care Tab**

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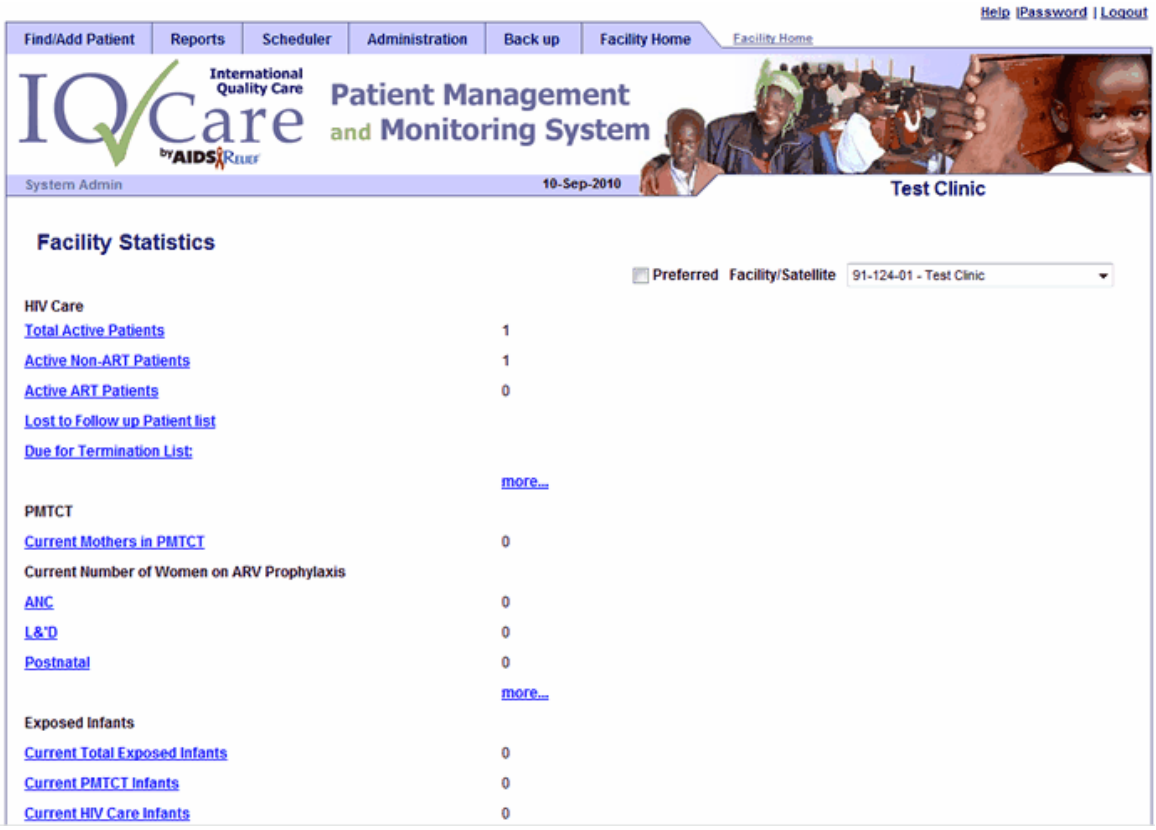

Label	Statistic Example	Business Rule – column 1	Business Rule – columns 2 & 3
Total Ever Enrolled :	495	Count the number of patients who have an ART enrollment form	
Females Ever Enrolled	305 (62%)	Count the number of female patients who have an ART enrollment form	
Males Ever Enrolled	190 (38%)	Count the number of male patients who have an ART enrollment form	
Total ART Ever Enrolled:	485	Count the number of ART patients who has a pharmacy form with ARVs or transferred in on ART	
Total Number of Active Patients:	479	Count number of ART patients who are not care ended (=Active Non-ART Patients + Active ART Patients + Stopped ART Patients + Due for Termination)	
Active Non-ART Patients:	150 (xx %)	Count the number of patients who have never had a pharmacy form	Use the “Active Non-ART Patients” statistic to

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Label	Statistic Example	Business Rule – column 1	Business Rule – columns 2 & 3
		with ARVs dispensed and are not care ended.	provide the age and sex breakdown Age and Sex Breakdown Males 0-1 :: Age 0 AND <2 2-4 :: Age>=2 AND Age<5 5-14 :: Age>=5 AND Age<15 15+ :: Age>=15 Females 0-1 :: Age 0 AND <2 2-4 :: Age>=2 AND Age<5 5-14 :: Age>=5 AND Age<15 15+ :: Age>=15
Active ART Patients:	275 (yy %)	Count the number of patients who's last pharmacy form with ARVs dispensed + longest duration + 90 days < today's date and Treatment program = ART and who does not have a care tracking form with "ART Ended but still in care" = yes lw comments May be useful to indicate the number of ART patients whose last pharmacy +longest duration+90 days>today's date as it means the site needs to terminate these patients and complete care tracking form. Is it possible to make this linkable so that when they click this button it runs a report showing who those patients are.	Use the "Active ART Patients" statistic to provide the age and sex breakdown Males 0-1 :: Age 0 AND <2 2-4 :: Age>=2 AND Age<5 5-14 :: Age>=5 AND Age<15 15+ :: Age>=15 Females 0-1 :: Age 0 AND <2 2-4 :: Age>=2 AND Age<5 5-14 :: Age>=5 AND Age<15 15+ :: Age>=15
Due for Termination	52	Count the number of patients who's last pharmacy form with ARVs dispensed + longest duration + 90 days > today's date and Treatment program = ART and who does not have a care tracking form with ART Care Ended = yes Link: Displays list of Due for	

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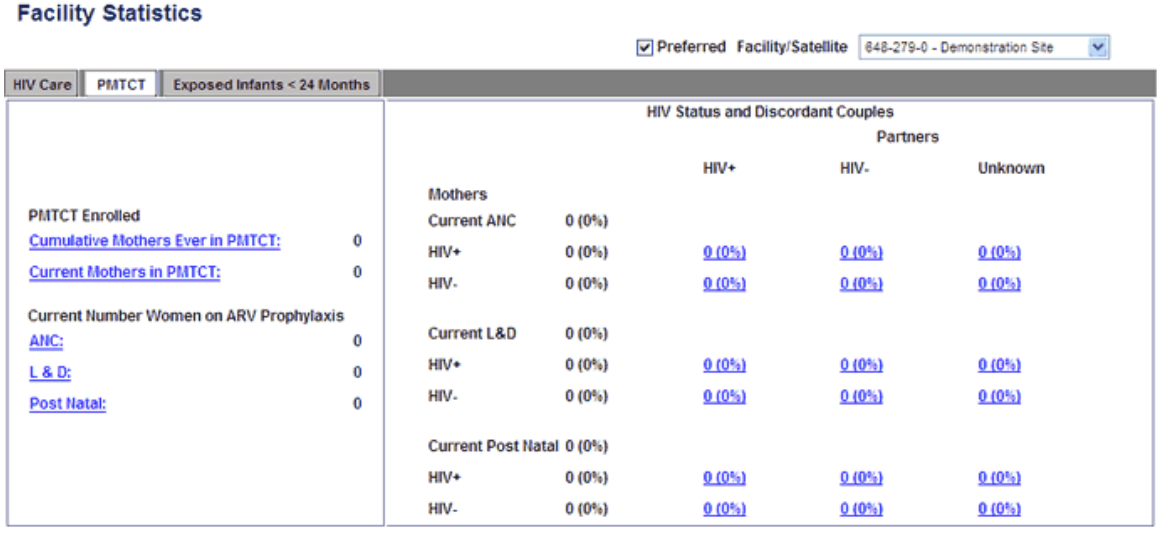
Label	Statistic Example	Business Rule – column 1	Business Rule – columns 2 & 3
		Termination patients – see example below. perfect	
Lost to Follow up Patient List		Display an excel sheet with the list of patients have the status of Lost to Follow up	
Due for Termination Patient List		Display an excel sheet with the list of patient who have the status of Due for Termination	

Percent Males and Females Ever Enrolled
- See chart equivalent for calculations

Percent Active ART and Non-ART
- See chart equivalent for calculations

Percent Active ART by Age
- Display 0-14 yrs and 15+ yrs
- See chart equivalent for calculations

PMTCT Tab


Facility Statistics
Preferred Facility/Satellite
648-279-0 - Demonstration Site
HIV Care
PMTCT
Exposed Infants < 24 Months
PMTCT Enrolled
Cumulative Mothers Ever in PMTCT: 0
Current Mothers in PMTCT: 0
Current Number Women on ARV Prophylaxis
ANC: 0
L & D: 0
Post Natal: 0
HIV Status and Discordant Couples
Partners
HIV+
HIV-
Unknown
Mothers
Current ANC 0 (0%)
HIV+ 0 (0%) 0 (0%) 0 (0%) 0 (0%)
HIV- 0 (0%) 0 (0%) 0 (0%) 0 (0%)
Current L&D 0 (0%)
HIV+ 0 (0%) 0 (0%) 0 (0%) 0 (0%)
HIV- 0 (0%) 0 (0%) 0 (0%) 0 (0%)
Current Post Natal 0 (0%)
HIV+ 0 (0%) 0 (0%) 0 (0%) 0 (0%)
HIV- 0 (0%) 0 (0%) 0 (0%) 0 (0%)

Label	Example	Business Rule
PMTCT Enrolled		
Cumulative Mothers Ever in PMTCT	3229 (a cumulative number)	Count the total number of women who's age at enrollment > 10 years old and had a PMTCT enrollment form

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Current Mothers in PMTCT	1256	Count the number of women who's age at enrollment > 10 years old and with a PMTCT Status = Active (no PMTCT care ended) If the latest visit date, latest adult pharmacy dispensed by date or latest lab reported by date + 90 days is < Today's date, then do not include these women. They are presumed to be lost to follow up.
Current Number of Women on ARV Prophylaxis (this number will be a subset of the Current Mothers in PMTCT – not every woman is on ARV prophylaxis; each group is mutually exclusive – a women in one group should not be counted in another group. Look at the latest pharmacy form.)		
ANC	565 (45%) [45=565/1256*100]	If the latest visit date, latest adult pharmacy dispensed by date or latest lab reported by date + 90 days is < Today's date, then do not include these women. Count the number of women who latest Adult pharmacy form with Treatment program = PMTCT During Pregnancy At least one ARV drug is dispensed Prophylaxis checked
L&D	314 (25%) [25=314/1256*100]	If the latest visit date, latest adult pharmacy dispensed by date or latest lab reported by date + 90 days is < Today's date, then do not include these women Count the number of women who latest Adult pharmacy form with Treatment program = PMTCT During Labour At least one ARV drug is dispensed Prophylaxis checked
Post Natal	126 (10%) [10=126/1256*100]	If the latest visit date, latest adult pharmacy dispensed by date or latest lab reported by date + 90 days is < Today's date, then do not include these women Count the number of women who latest Adult pharmacy form with Treatment program = PMTCT During Post Natal At least one ARV drug is dispensed Prophylaxis checked
HIV Status and Discordant Couples (Current ANC, Current L&D and Current Post Natal should add up to Current Mothers in PMTCT; there should not be any double counting)		
Mothers		
Current ANC	691 (55%) [60=691/1256*100]	Count the number of women who's age at enrollment > 10 years old and with a PMTCT Status = Active (no PMTCT care ended) and who's last register form is an ANC type form

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		HIV+ and HIV- current ANC women should add up to this number
HIV+	670 (97%) [97=670/691*100]	Count the number of women who's age at enrollment > 10 years old and with a PMTCT Status = Active (no PMTCT care ended) and who's last register form is an ANC type form AND Who's HIV Status= positive
HIV-	21 (3%) [3=21/691*100]	Count the number of women who's age at enrollment > 10 years old and with a PMTCT Status = Active (no PMTCT care ended) and who's last register form is an ANC type form AND Who's HIV Status= negative (Unknown should not be an option for this field)
Current L&D	314 (25%) [25=314/1256*100]	Count the number of women who's age at enrollment > 10 years old and with a PMTCT Status = Active (no PMTCT care ended) and who's last register form is an L&D type form HIV+ and HIV- current L&D women should add up to this number
HIV+		Count the number of women who's age at enrollment > 10 years old and with a PMTCT Status = Active (no PMTCT care ended) and who's last register form is an L&D type form AND Who's HIV Status= positive
HIV-		Count the number of women who's age at enrollment > 10 years old and with a PMTCT Status = Active (no PMTCT care ended) and who's last register form is an L&D type form AND Who's HIV Status= negative (Unknown should not be an option for this field)
Current Post Natal	251 (20%) [20=251/1256*100]	Count the number of women who's age at enrollment > 10 years old and with a PMTCT Status = Active (no PMTCT care ended) and who's last register form is an PN type form HIV+ and HIV- current Post Natal women should add up to this number
HIV+		Count the number of women who's age at enrollment > 10 years old and with a PMTCT Status = Active (no PMTCT care ended) and who's last register form is an PN type form HIV+ and HIV- current L&D women should add up to this number
HIV-		Count the number of women who's age at enrollment > 10 years old and with a PMTCT Status = Active (no PMTCT

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		care ended) and who's last register form is an PN type form AND Who's HIV Status= positive
Partners		
Current ANC – HIV+ women	670 (97%) [97=670/691*100	See calculation above HIV+ + HIV- + Unknown = number of HIV+ ANC women 134+101+435 = 670
HIV+ (partner)	134 (20%) [20=134/670*100]	Associated with the HIV+ women counted in the ANC group, count the number of partners with a HIV status of Positive
HIV- (partner)	101 (15%) [15=101/670*100]	Associated with the HIV+ women counted in the ANC group, count the number of partners with a HIV status of Negative
Unknown (partner)	435 (65%) [65=435/670*100]	Associated with the HIV+ women counted in the ANC group, count the number of partners with a HIV status of Unknown
Current ANC – HIV- women	21 (3%) [3=21/691*100]	See calculation above HIV+ + HIV- + Unknown = number of HIV- ANC women 2+1+18=21
HIV+ (partner)	2 (10%) [10 = 2/21*100]	Associated with the HIV- women counted in the ANC group, count the number of partners with a HIV status of Positive
HIV- (partner)	1 (5%) [5=1/21*100]	Associated with the HIV- women counted in the ANC group, count the number of partners with a HIV status of Negative
Unknown (partner)	18 (85%) [85=18/21*100]	Associated with the HIV- women counted in the ANC group, count the number of partners with a HIV status of Unknown
Current L&D		Repeat sequence for L&D
Current Post Natal		Repeat sequence for Post Natal

- **Exposed Infants Tab**

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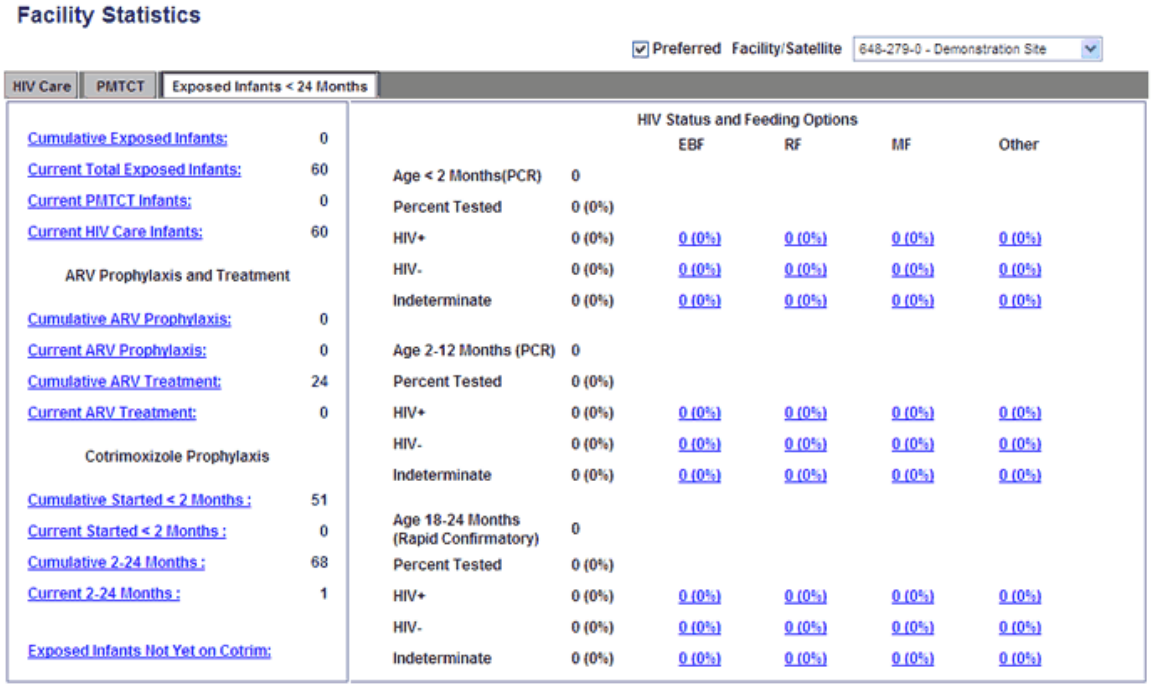
Facility Statistics
Preferred Facility/Satellite
648-279-0 - Demonstration Site
HIV Care
PMTCT
Exposed Infants < 24 Months
Cumulative Exposed Infants: 0
Current Total Exposed Infants: 60
Current PMTCT Infants: 0
Current HIV Care Infants: 60
ARV Prophylaxis and Treatment
Cumulative ARV Prophylaxis: 0
Current ARV Prophylaxis: 0
Cumulative ARV Treatment: 24
Current ARV Treatment: 0
Cotrimoxizole Prophylaxis
Cumulative Started < 2 Months : 51
Current Started < 2 Months : 0
Cumulative 2-24 Months : 68
Current 2-24 Months : 1
Exposed Infants Not Yet on Cotrim:
HIV Status and Feeding Options
EBF
RF
MF
Other
Age < 2 Months(PCR) 0
Percent Tested 0 (0%)
HIV+ 0 (0%) 0 (0%) 0 (0%) 0 (0%) 0 (0%)
HIV- 0 (0%) 0 (0%) 0 (0%) 0 (0%) 0 (0%)
Indeterminate 0 (0%) 0 (0%) 0 (0%) 0 (0%) 0 (0%)
Age 2-12 Months (PCR) 0
Percent Tested 0 (0%)
HIV+ 0 (0%) 0 (0%) 0 (0%) 0 (0%) 0 (0%)
HIV- 0 (0%) 0 (0%) 0 (0%) 0 (0%) 0 (0%)
Indeterminate 0 (0%) 0 (0%) 0 (0%) 0 (0%) 0 (0%)
Age 18-24 Months (Rapid Confirmatory) 0
Percent Tested 0 (0%)
HIV+ 0 (0%) 0 (0%) 0 (0%) 0 (0%) 0 (0%)
HIV- 0 (0%) 0 (0%) 0 (0%) 0 (0%) 0 (0%)
Indeterminate 0 (0%) 0 (0%) 0 (0%) 0 (0%) 0 (0%)

Label	Example	Business Rule
Cumulative Exposed Infants	1230	Count the number of infants strictly less than 24 months old that have a PMTCT registration form
Current Exposed Infants	308 = 290 + 18	Count the number of infants strictly less than 24 months old that have a PMTCT registration form and do not have a care ended form (their patient status = PMTCT active) OR Count the number of infants strictly less than 24 months old that have an ART registration form and do not have an care ended form (their patient status = ART active) Do not double count; this represents the entire population of exposed infants from both sources – PMTCT and ART Current PMTCT Infants plus Current HIV Care Infants = Current Exposed Infants
Current PMTCT Infants	290	Count the number of infants strictly less than 24 months old that have a PMTCT registration form and do not have a care ended form (their patient status = PMTCT active) Include any status of active infant -- the
Current HIV Care Infants	18	Count the number of infants strictly less than 24 months old that have an ART registration form and do not have an care ended form (their patient status = ART active) Include all infants even if they have not had ARVs dispensed.
HIV Status and Feedings Options		

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Age < 2 Months (PCR)	64	Count the total number of current PMTCT infants less than 2 months old as of the today's date Display the number of infants
Number/Percent Tested	36 (57%) [57= 36/64*100] 36=8+25 +3 100%~22 +69+8	Count the total number of current PMTCT infants less than 2 months of age at the reported by date who had a PCR test Display the number of infants and the percent of the total number of infants less than 2 months old
HIV+	8 (22%) [22=8/36* 100]	Of the number of infants less than 2 months old, display the number who tested positive Display the percentage of positive infants with the total number of < 2 months tested
HIV-	25 (69%) [69=25/36 *100]	Of the number of infants less than 2 months old, display the number who tested negative Display the percentage of positive infants with the total number of < 2 months tested
Indeterminate	3 (8%) [8=3/36*1 00]	Of the number of infants less than 2 months old, display the number who tested indeterminate Display the percentage of positive infants with the total number of < 2 months tested
HIV+ -- EBF	8 (100%)	Of the HIV+ < 2 months old population, display the number of infants who last Post Natal register has the EBF option selected Display the percentage of HIV+ < 2 months infants who are EBF
HIV+ -- RF	0 (0%)	Of the HIV+ < 2 months old population, display the number of infants who last Post Natal register has the RF option selected Display the percentage of HIV+ < 2 months infants who are RF
HIV+ -- MF	0 (0%)	Of the HIV+ < 2 months old population, display the number of infants who last Post Natal register has the MF option selected Display the percentage of HIV+ < 2 months infants who are MF
HIV+ -- Other	0 (0%)	Of the HIV+ < 2 months old population, display the number of infants who last Post Natal register has the Other option selected Display the percentage of HIV+ < 2 months infants who are Other
HIV- -- EBF	21 (85%) [85= 21/25*100]	Of the HIV- < 2 months old population, display the number of infants who last Post Natal register has the EBF option selected Display the percentage of HIV- < 2 months infants who are EBF

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HIV- -- RF	5 (15%) [15=4/25* 100]	Of the HIV- < 2 months old population, display the number of infants who last Post Natal register has the RF option selected Display the percentage of HIV- < 2 months infants who are RF
HIV- -- MF	0 (0%)	Of the HIV- < 2 months old population, display the number of infants who last Post Natal register has the MF option selected Display the percentage of HIV- < 2 months infants who are MF
HIV- -- Other	0 (0%)	Of the HIV- < 2 months old population, display the number of infants who last Post Natal register has the Other option selected Display the percentage of HIV- < 2 months infants who are Other
Indeterminate -- EBF	2 (67%)	Of the Indeterminate < 2 months old population, display the number of infants who last Post Natal register has the EBF option selected Display the percentage of Indeterminate < 2 months infants who are EBF
Indeterminate -- RF	1 (33%)	Of the Indeterminate < 2 months old population, display the number of infants who last Post Natal register has the RF option selected Display the percentage of Indeterminate < 2 months infants who are RF
Indeterminate -- MF	0 (0%)	Of the Indeterminate < 2 months old population, display the number of infants who last Post Natal register has the MF option selected Display the percentage of Indeterminate < 2 months infants who are MF
Indeterminate -- Other	0 (0%)	Of the Indeterminate < 2 months old population, display the number of infants who last Post Natal register has the Other option selected Display the percentage of Indeterminate < 2 months infants who are Other
Age 2-12 Months (PCR)		Repeat above for ages greater than or equal 2 months to strictly less than 12 months Use PCR test
Number/Percent Tested		
HIV+		
HIV-		
Indeterminate		

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HIV+ -- EBF		
HIV+ -- RF		
HIV+ -- MF		
HIV+ -- Other		
HIV- -- EBF		
HIV- -- RF		
HIV- -- MF		
HIV- -- Other		
Age 18-24 Months (Rapid Confirmatory)		Repeat above for ages greater than or equal 18 months to strictly less than 24 months Use a Rapid Test with Confirmatory checked Note that with a Rapid test, Indeterminate is not an option – so there will only be two rows
Number/Percent Tested		
HIV+		
HIV-		
HIV+ -- EBF		
HIV+ -- RF		
HIV+ -- MF		
HIV+ -- Other		
HIV- -- EBF		
HIV- -- RF		
HIV- -- MF		
HIV- -- Other		
Number/Percent Tested		
ARV Prophylaxis and Treatment		
Cumulative ARV Prophylaxis	982 (a cumulative	Count the total number of infants ever enrolled in PMTCT with at least one pediatric pharmacy form where ARVs

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	number)	were dispensed as prophylaxis.
Current ARV Prophylaxis	58 (20%) [20=58/290*100]	Count the number of infants current in PMTCT with the latest pediatric pharmacy form where ARVs were dispensed as prophylaxis and that the dispensed by date plus the longest duration >= today's date A patient current on ARV prophylaxis should not be counted in the group of patients current on ARV Treatment. Display the number and the percent of the current number of exposed PMTCT infants
Cumulative ARV Treatment	391 (a cumulative number)	Count the total number of infants ever enrolled in ART with at least one pediatric pharmacy form where ARVs were dispensed as treatment. An infant counted in this group may have been counted in the cumulative ARV prophylaxis group.
Current ARV Treatment	9 (50%) [50=9/18*100]	Count the number of infants current in ART with the latest pediatric pharmacy form where ARVs were dispensed as treatment and that the dispensed by date plus the longest duration >= today's date Display the number and the percent of the current number of exposed ART infants A patient current on ARV treatment should not be counted in the group of patients current on ARV prophylaxis.
Cotrimoxizole Prophylaxis		
Cumulative Started < 2 Months	963 (a cumulative number)	Count the cumulative number of infants enrolled in PMTCT OR HIV Care who was had a pediatric pharmacy form with Septim/TMX (Cotrimoxizole) dispensed and age is strictly less than 2 at the time the drug was dispensed.
Current Started < 2 Months	59 (92%) [83=59/64*100]	Count the number of infants in PMTCT OR HIV Care aged strictly less than 2 months who has a pediatric pharmacy form with Septim/TMX (Cotrimoxizole) dispensed where the dispensed by date plus the duration is greater than or equal to today's date.
Cumulative Started 2-24 Months	1-28 (a cumulative number)	Count the cumulative number of infants enrolled in PMTCT OR HIV Care who was had a pediatric pharmacy form with Septim/TMX (Cotrimoxizole) dispensed and age is 2 months to strictly less then 24 months at the time the drug was dispensed.
Current Started < 2-24 Months	102 (70%) 70=102/145*100	Count the number of infants in PMTCT OR HIV Care aged 2 months to strictly less than 24 months who has a pediatric pharmacy form with Septim/TMX (Cotrimoxizole) dispensed where the dispensed by date plus the duration is greater than or equal to today's date.
Exposed Infants Not Yet on Cotrim		Display an Excel spreadsheet displaying infants current in PMTCT and the latest pediatric pharmacy form with

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		Cotrim dispensed. Display patient name, Admissions number, Outpatient number, Mother's name, Mother's outpatient number, last visit date (date of latest lab, pediatric pharmacy form, Post Natal visit date)

3.3 Facility and Patient Navigation

Facility Level Navigation

- **Find/Add Patient** – allows you to find an existing patient or add (enroll) new patient
- **Reports** – allows you to run patient, facility or donor reports.
  - Donor reports
  - Facility reports
  - Custom reports
- **Scheduler** – allows you to view appointments for the facility and schedule individual patient appointments
- **Administration** – allows you to set up the IQCare application for your facility, update custom lists, administer access security for the application, delete a patient, export data and configure custom fields.
  - Facility Setup
  - Customize List
  - User Administration
  - User Group Administration
  - Delete Patient
  - Configure Custom Fields
  - Export
  - Refresh System Cache
- **Back Up/Restore** – allows you to configure and start the back up routine for the IQCare database
  - Backup/Restore Database
  - Backup/Restore Setup
- **Facility Home** – brings you back to the Facility Home page

Patient Level Navigation

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- **Registration** – allows you to view and update a patient's registration form. If HIV Care Static Forms are active (activated in the Facility Setup) then the HIV Care Enrollment form also displays
  - HIV Care Enrollment
  - Patient Registration
- **Transfer** – allows you to transfer a patient from one location to another
- **Additional Forms** – allows you to enter information into grid-type form for a patient
  - Family Information
- **View Existing Forms** – allows you to view all of a patient's previously filled in forms
- **Create New Form** – allows you to create a new form for a patient; the forms that display are directly dependent on the technical area that is active for the patient
- **Delete Form** – allows you to delete a filled in form
- **Patient Reports** – allows you to run patient reports
  - Patient ARV Pick up
  - HIV Care Patient Profile
- **Schedule App**. – allows you to schedule an appointment for a particular patient
- **Patient Home** – a link that brings you back to the Patient Home page for a particular patient

3.4 Find/Add Patient

The Find/Add link takes you to a search page where you can find an existing patient or enroll a new patient. The search criteria allow you to drill down to a single patient or view the entire list of patients in facility.

Search for a patient

- To search for a patient, click on the Find button without any search criteria and you will see the entire list of patients for a particular facility/satellite
- To search for a specific existing patient enter search criteria and click on the Find button.
- Any number can be used to search for a patient. The full number must be entered.

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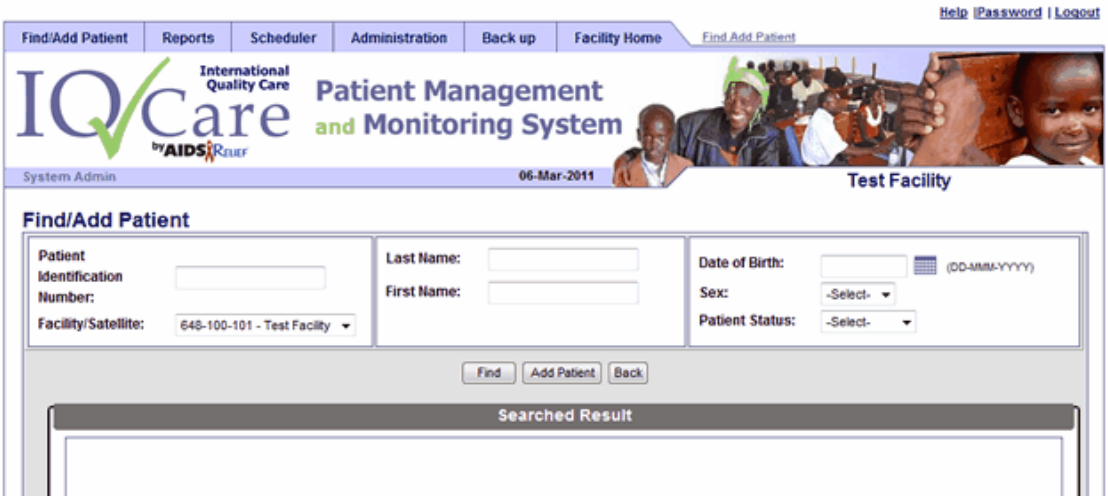

- **Add a Patient**

  To add a new patient, click the Add Patient button; an empty registration form will display

- **Auto-fill patient data into the registration form**

  It is not uncommon to enter information into the Find/Add fields, thinking that you are starting an registration form. If you do enter information into these fields and then click on the Add Patient button, the information you entered in the Find/Add page will populate into the appropriate Registration form fields so that you don't have to re-enter the information.

3.4.1 Find/Add Patients and Location

- The Find/Add page lets you filter on the available locations that have been set up through the Facility Setup page in the Administration module.
- All patients in the IQCare database can be searched, but only those patients whose location is the same as the logged-in location can be accessed.
- If you search for a patient in a location other than the location you have logged-in with and attempt to access the patient record, IQCare will display and error message.

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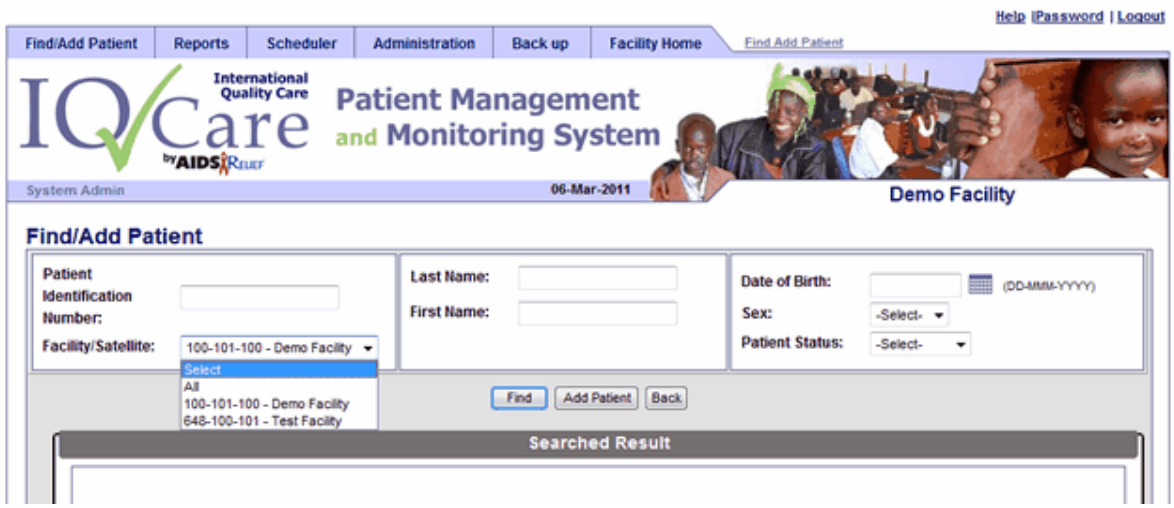
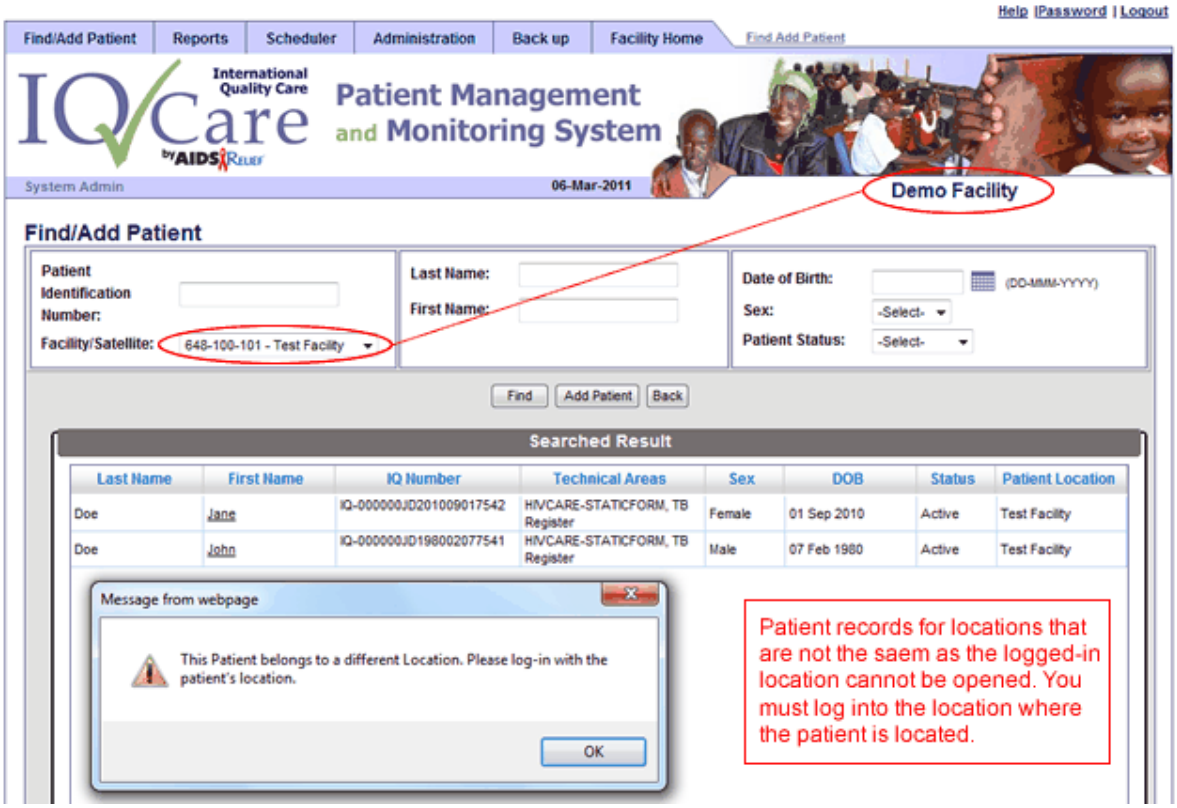


Here the logged location is Demo Clinic - but patient is located in the Test Facility. You can view the patient names, but if you attempt to drill down to see the patient record, you will get a user error.



3.5 Appointment Scheduler

The scheduler allows the facility administrator to manage the patients who are expected to arrive for Today's appointments, those patients who have missed their appointment and to schedule individual

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patient appointments.

The Scheduler provides features for creating, updating and deleting appointments for a facility. It is integrated with the appointments scheduled in the Initial Evaluation and Follow up forms and monitors various dates when a patient was served by the clinic. Specific views are provided to help the facility administrator manage the patient flow within the clinic.

Scheduler Information and Display

- The scheduler's primary function is to help the facilities know the number and name of individuals that are expected to arrive on any particular day with a pending appointment. As well, views of patients with other types of status such as met or missed, should help the clinic manage patient adherence.
- From a clinical process perspective, the primary way appointments are made is through the Initial Evaluation and the Follow up forms. The scheduler provides the ability for healthcare providers to schedule appointments outside the forms, should they wish to.
- The scheduler captures the following information for each appointment. Note that the appointment time and type are not required.
  - Appointment date
  - Appointment reason
  - Healthcare provider
  - Appointment status
- There are three views of appointments available from the Scheduler home page:
  - All Pending Appointments (default view)
  - All Missed Appointments
  - All Appointments (requires a date range for display)
- You can schedule two appointments for a person as long at the purpose is different
  - For example, you can schedule an appointment for a lab appointment (possibility for a CD4 test) outside of the forms and a follow up appointment through the forms
  - You can schedule more than one appointment for a patient on different dates with the same or different appointment purposes.
  - You can schedule more than one appointment with different appointment purposes on the same date

Grace Period

- The grace period is the number of days before and after an appointment, specifying the range of dates for which a patient may attend an appointment before it is deemed "Missed." For example, if the grace period is 2 days, the range for which an appointment can be attended and still be deemed as "Met" is 5 days. Suppose a patient has an appointment on May 3rd. The appointment range is from May 1-May5.
- Grace period includes weekend
- The grace period is taken into consideration when calculating if an appointment has been met or missed
- The longer the grace period is, the fewer missed appointments your clinic will record
- The grace period is set in the Facility Setup page

Appointments Made via Patient Forms

- Only one appointment can be made through a form
- The primary provider on the form from which the appointment is created is the provider for the appointment.
- New appointments have the appointment status of "Pending."

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- If a previous appointment exists and is “Pending” and is after the visit date of the form, then it is assumed to still be a pending appointment. If the pending appointment is before the visit date, then it is assumed to be met.
- The form visit date should be saved in the IQCare database so that changes to a scheduled appointment from a form can be done in the future.

Appointment Status Definitions
- Pending -- A patient has an appointment that he/she has yet to attend
- Met -- A patient has attended an appointment within the grace period range.
- Missed -- A patient did not attend an appointment including the time of the grace period range.
- Previously Missed -- A patient has missed an appointment and a new appointment is made and is pending.
- Care Ended -- A patient did not attend an appointment because care has ended.

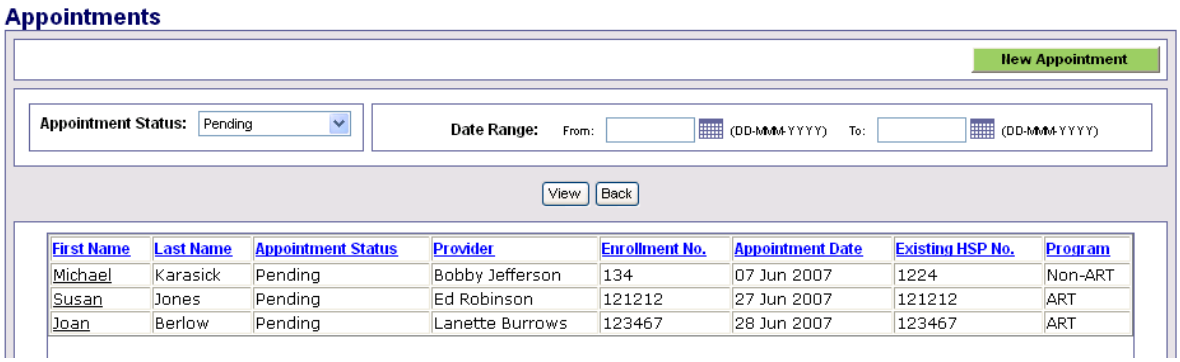
See Scheduler Update Process for more details.

Appointment Location
- If a patient has an appointment in one location and is transferred to a new location, then the appointment date gets transferred as well
- Scheduled appointments display for the logged-in location

3.5.1 Scheduler Appointment Views

There are three views available from the scheduler home page: Pending appointments, Missed appointments and All appointments. Pending appointments is the default view.

Pending Appointments
The default view, upon clicking on the Scheduler link in the Facility level navigation, is the Pending appointments view. This shows all of the pending appointments in reverse chronological order, for the clinic.


Appointments
New Appointment
Appointment Status: Pending
Date Range: From: (DD-MMM-YYYY) To: (DD-MMM-YYYY)
View
Back
First Name | Last Name | Appointment Status | Provider | Enrollment No. | Appointment Date | Existing HSP No. | Program
Michael | Karasick | Pending | Bobby Jefferson | 134 | 07 Jun 2007 | 1224 | Non-ART
Susan | Jones | Pending | Ed Robinson | 121212 | 27 Jun 2007 | 121212 | ART
Joan | Berlow | Pending | Lanette Burrows | 123467 | 28 Jun 2007 | 123467 | ART

If you want to see the pending appointments for a particular date range or for one day, enter the beginning and end date range and click the View button. To see today’s appointments, enter today’s date in the from and to fields.

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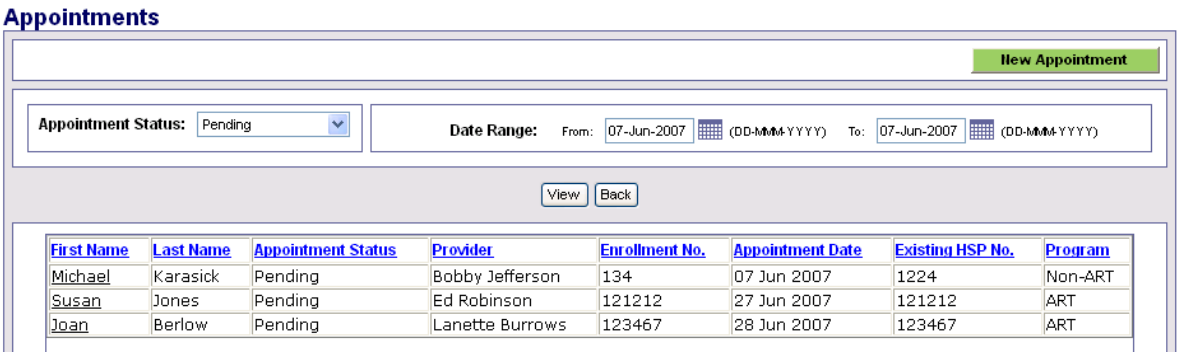
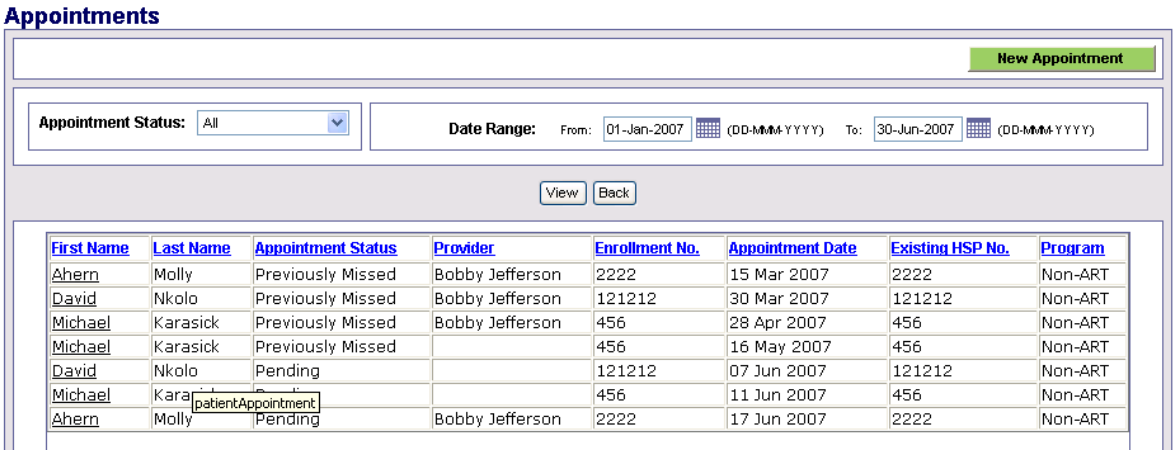

Appointments
New Appointment
Appointment Status: Pending
Date Range: From: 07-Jun-2007 (DD-MMM-YYYY) To: 07-Jun-2007 (DD-MMM-YYYY)
View Back
First Name | Last Name | Appointment Status | Provider | Enrollment No. | Appointment Date | Existing HSP No. | Program
Michael | Karasick | Pending | Bobby Jefferson | 134 | 07 Jun 2007 | 1224 | Non-ART
Susan | Jones | Pending | Ed Robinson | 121212 | 27 Jun 2007 | 121212 | ART
Joan | Berlow | Pending | Lanette Burrows | 123467 | 28 Jun 2007 | 123467 | ART

Missed Appointments
Missed appointments work in the same way as pending appointments. All of the missed appointments are displayed in reverse chronological order.

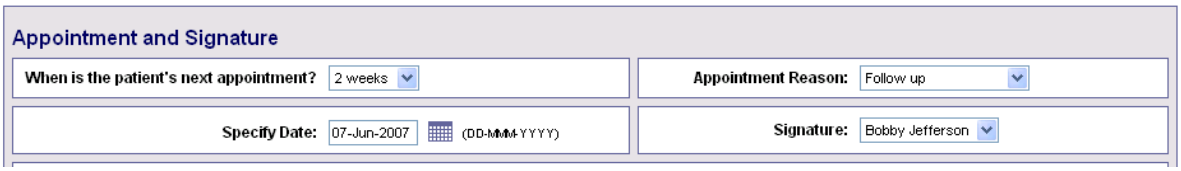
All Appointments
All appointments require that you enter in a date range before you can view results. All appointments displays all appointments for all appointment status types.


Appointments
New Appointment
Appointment Status: All
Date Range: From: 01-Jan-2007 (DD-MMM-YYYY) To: 30-Jun-2007 (DD-MMM-YYYY)
View Back
First Name | Last Name | Appointment Status | Provider | Enrollment No. | Appointment Date | Existing HSP No. | Program
Ahern | Molly | Previously Missed | Bobby Jefferson | 2222 | 15 Mar 2007 | 2222 | Non-ART
David | Nkolo | Previously Missed | Bobby Jefferson | 121212 | 30 Mar 2007 | 121212 | Non-ART
Michael | Karasick | Previously Missed | Bobby Jefferson | 456 | 28 Apr 2007 | 456 | Non-ART
Michael | Karasick | Previously Missed | | 456 | 16 May 2007 | 456 | Non-ART
David | Nkolo | Pending | | 121212 | 07 Jun 2007 | 121212 | Non-ART
Michael | Kara | | | 456 | 11 Jun 2007 | 456 | Non-ART
Ahern | Molly | Pending | Bobby Jefferson | 2222 | 17 Jun 2007 | 2222 | Non-ART
patientAppointment

3.5.2 New Appointment Via A Form

In general, appointments are made through the Initial Evaluation and Follow up forms. At the end of each of these forms there is an Appointment and Signature section. The next appointment can be automatically determined with respect to the visit date, by selecting 1 week, 2 weeks, etc, or you can specific a specific date. The appointment reason field specifies the reason and the Signature field specifies the Provider for the next appointment.

Appointment information saved via the Initial Evaluation or the Follow up forms can be changed by finding the specific from for the patient, changing it and re-saving.


Appointment and Signature
When is the patient's next appointment? 2 weeks
Appointment Reason: Follow up
Specify Date: 07-Jun-2007 (DD-MMM-YYYY)
Signature: Bobby Jefferson

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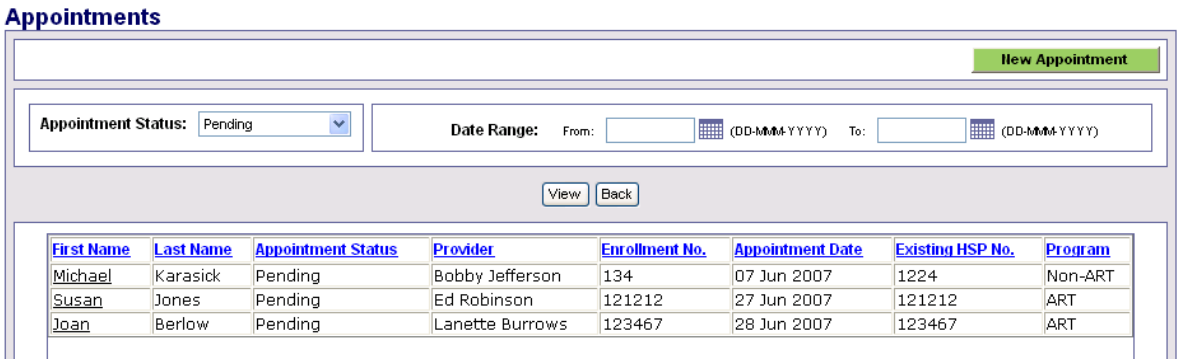
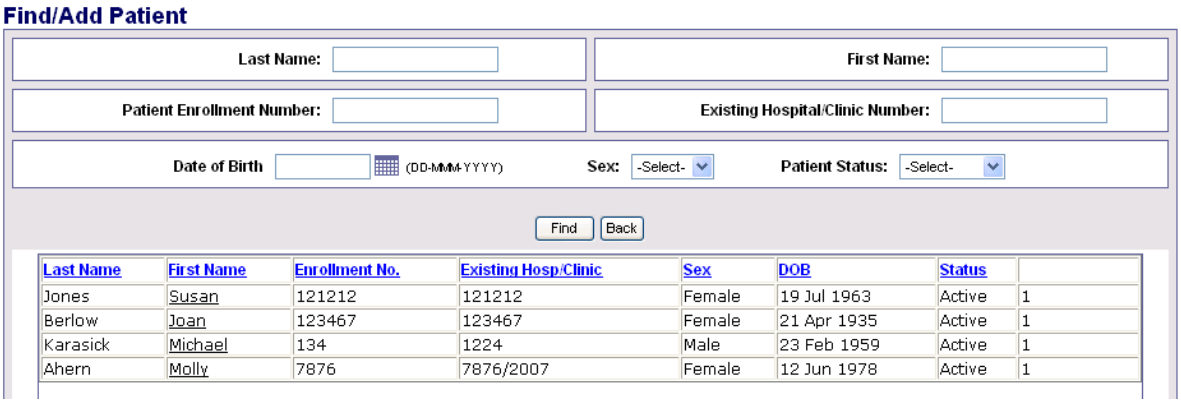
3.5.3 New Appointment Via The Scheduler

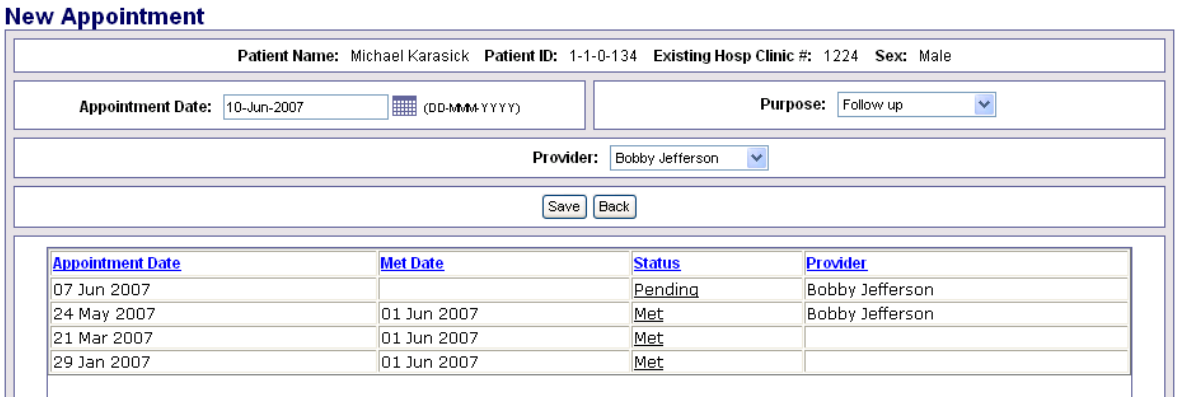
1. From the Scheduler home page, click on the New Appointment button


Appointments
New Appointment
Appointment Status: Pending
Date Range: From: (DD-MMM-YYYY) To: (DD-MMM-YYYY)
View
Back
First Name | Last Name | Appointment Status | Provider | Enrollment No. | Appointment Date | Existing HSP No. | Program
Michael | Karasick | Pending | Bobby Jefferson | 134 | 07 Jun 2007 | 1224 | Non-ART
Susan | Jones | Pending | Ed Robinson | 121212 | 27 Jun 2007 | 121212 | ART
Joan | Berlow | Pending | Lanette Burrows | 123467 | 28 Jun 2007 | 123467 | ART

2. Find the patient by entering search criteria or clicking the Find button to view all of the patients


Find/Add Patient
Last Name:
First Name:
Patient Enrollment Number:
Existing Hospital/Clinic Number:
Date of Birth (DD-MMM-YYYY)
Sex: -Select-
Patient Status: -Select-
Find
Back
Last Name | First Name | Enrollment No. | Existing Hosp/Clinic | Sex | DOB | Status
Jones | Susan | 121212 | 121212 | Female | 19 Jul 1963 | Active | 1
Berlow | Joan | 123467 | 123467 | Female | 21 Apr 1935 | Active | 1
Karasick | Michael | 134 | 1224 | Male | 23 Feb 1959 | Active | 1
Ahern | Molly | 7876 | 7876/2007 | Female | 12 Jun 1978 | Active | 1

3. Click on the patient for which you want to make an appointment
4. Enter the appointment date, the purpose and the provider


New Appointment
Patient Name: Michael Karasick Patient ID: 1-1-0-134 Existing Hosp Clinic #: 1224 Sex: Male
Appointment Date: 10-Jun-2007 (DD-MMM-YYYY)
Purpose: Follow up
Provider: Bobby Jefferson
Save
Back
Appointment Date | Met Date | Status | Provider
07 Jun 2007 | | Pending | Bobby Jefferson
24 May 2007 | 01 Jun 2007 | Met | Bobby Jefferson
21 Mar 2007 | 01 Jun 2007 | Met |
29 Jan 2007 | 01 Jun 2007 | Met |

5. Click save

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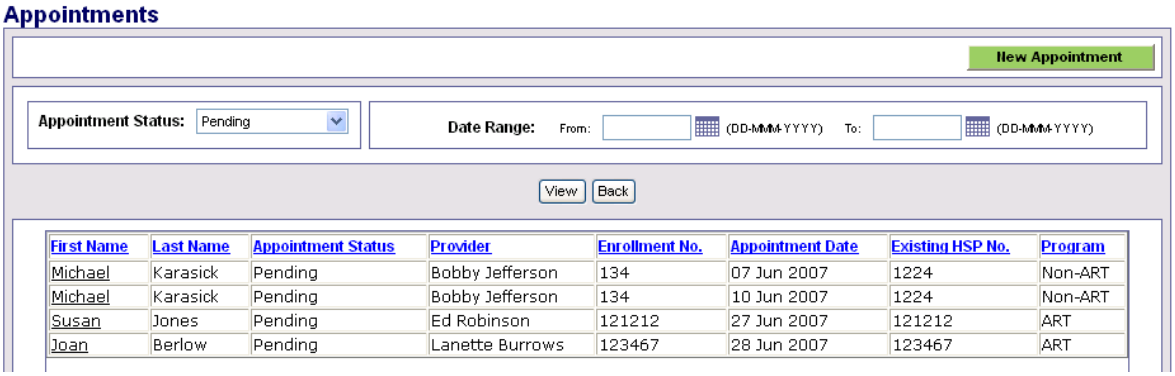
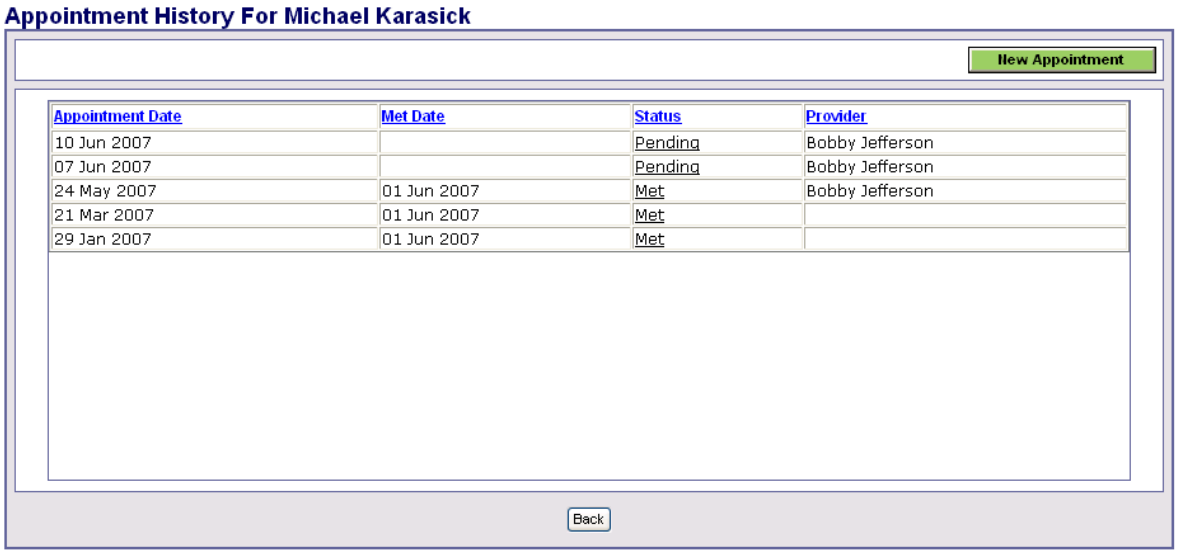
6. The new pending appointment will be displayed in the pending appointment view as per the date of the appointment



First Name	Last Name	Appointment Status	Provider	Enrollment No.	Appointment Date	Existing HSP No.	Program
Michael	Karasick	Pending	Bobby Jefferson	134	07 Jun 2007	1224	Non-ART
Michael	Karasick	Pending	Bobby Jefferson	134	10 Jun 2007	1224	Non-ART
Susan	Jones	Pending	Ed Robinson	121212	27 Jun 2007	121212	ART
Joan	Berlow	Pending	Lanette Burrows	123467	28 Jun 2007	123467	ART

3.5.4 New Appointment Via The Patient Home Page

1. Navigate to the patient's home page
2. Click on the Schedule Appointment link found in the Patient level navigation. The patient's appointment history is displayed.



Appointment Date	Met Date	Status	Provider
10 Jun 2007		Pending	Bobby Jefferson
07 Jun 2007		Pending	Bobby Jefferson
24 May 2007	01 Jun 2007	Met	Bobby Jefferson
21 Mar 2007	01 Jun 2007	Met	
29 Jan 2007	01 Jun 2007	Met	

3. Click on the New Appointment button
4. Enter the appointment date, purpose and provider
5. Click Save

3.5.5 Edit An Appointment Via the Scheduler

1. From the Scheduler home page, from any of the available views, click on the name of the person for whom you want to change the appointment

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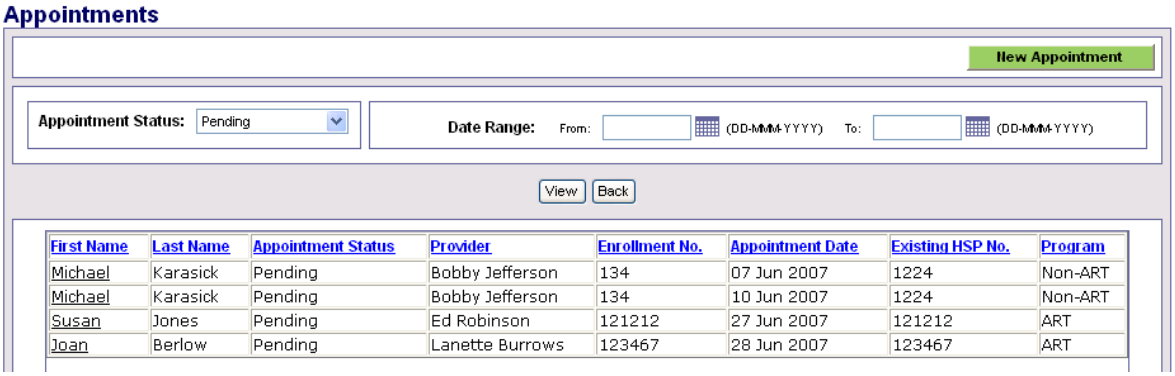
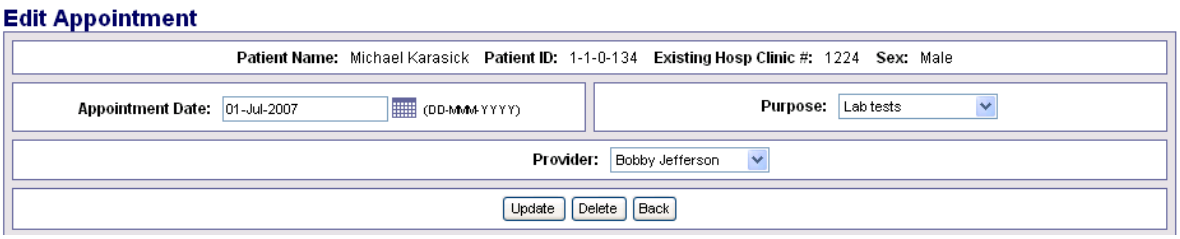
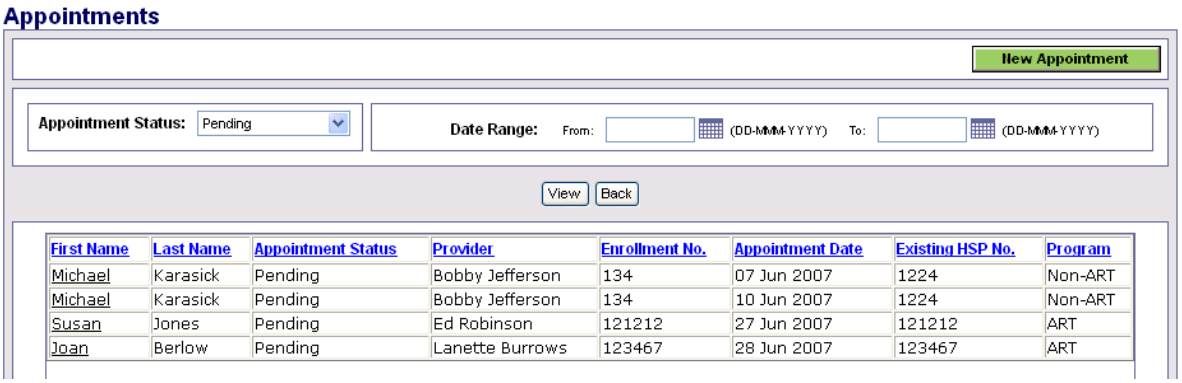

Appointments
New Appointment
Appointment Status: Pending
Date Range: From: (DD-MMM-YYYY) To: (DD-MMM-YYYY)
View Back
First Name | Last Name | Appointment Status | Provider | Enrollment No. | Appointment Date | Existing HSP No. | Program
Michael | Karasick | Pending | Bobby Jefferson | 134 | 07 Jun 2007 | 1224 | Non-ART
Michael | Karasick | Pending | Bobby Jefferson | 134 | 10 Jun 2007 | 1224 | Non-ART
Susan | Jones | Pending | Ed Robinson | 121212 | 27 Jun 2007 | 121212 | ART
Joan | Berlow | Pending | Lanette Burrows | 123467 | 28 Jun 2007 | 123467 | ART

2. The existing appointment information is populated and is editable. Make changes to the date, purpose or provider


Edit Appointment
Patient Name: Michael Karasick Patient ID: 1-1-0-134 Existing Hosp Clinic #: 1224 Sex: Male
Appointment Date: 01-Jul-2007 (DD-MMM-YYYY)
Purpose: Lab tests
Provider: Bobby Jefferson
Update Delete Back

3. Click Update to save the changes
4. The changes will be displayed in the pending appointment view as per the date of the appointment


Appointments
New Appointment
Appointment Status: Pending
Date Range: From: (DD-MMM-YYYY) To: (DD-MMM-YYYY)
View Back
First Name | Last Name | Appointment Status | Provider | Enrollment No. | Appointment Date | Existing HSP No. | Program
Michael | Karasick | Pending | Bobby Jefferson | 134 | 07 Jun 2007 | 1224 | Non-ART
Michael | Karasick | Pending | Bobby Jefferson | 134 | 10 Jun 2007 | 1224 | Non-ART
Susan | Jones | Pending | Ed Robinson | 121212 | 27 Jun 2007 | 121212 | ART
Joan | Berlow | Pending | Lanette Burrows | 123467 | 28 Jun 2007 | 123467 | ART

3.5.6 Edit An Appointment Via the Patient Home Page

1. Navigate to the patient's home page
2. Click on the Schedule Appointment link found in the Patient level navigation. The patient's appointment history is displayed.

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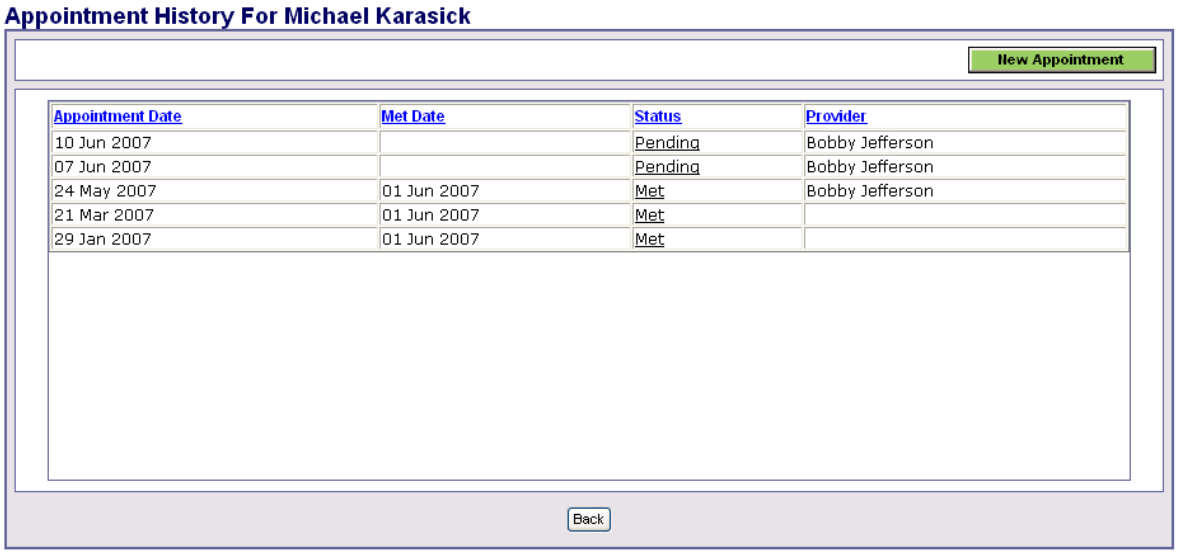
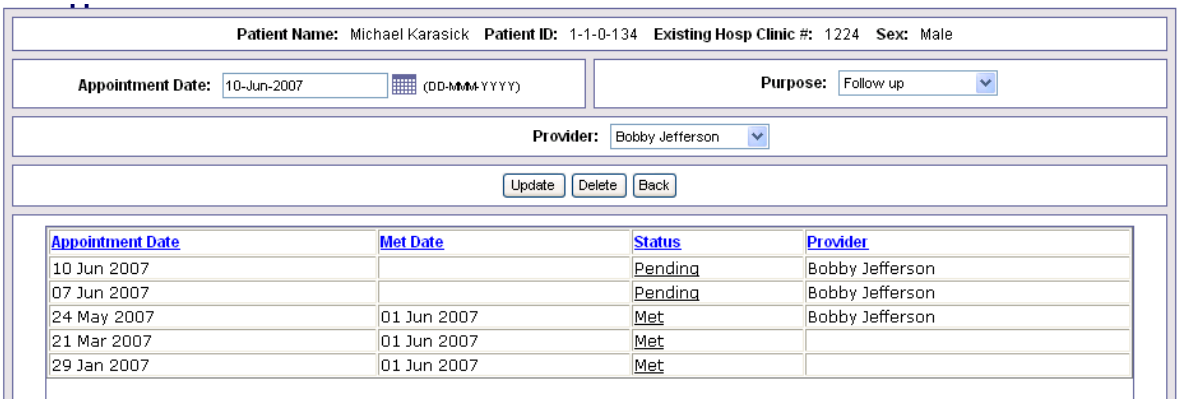


3. The existing appointment information is populated and is editable. Make changes to the date, purpose or provider



4. Click Update to save the changes
5. The patient's schedule history is updated

3.5.7 Scheduler Update Process

Status	Definition and Update Process	Form and date driving the status change
Pending	Definition: A patient has an appointment that he/she has yet to attend. Update Process: When a patient has an initial evaluation, the provider fills out the Initial Evaluation form and specifies on the form the next appointment date. This sets the appointment process in motion. Note also that the	Initial Evaluation • Visit date Follow up • Visit date

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	primary provider specified on the form is the provider for the next appointment. The appointment is set with the status of Pending. A patient can have more than one pending appointment.	
Met	Definition: A patient has attended an appointment within the grace period range. Update Process: The patient comes in at the specified date (or within the grace period) for one or more reasons – for a follow up exam, to pick up medication or to have lab tests. Any of these actions are considered meeting an appointment. When these forms are entered into IQCare, IQCare detects that a patient activity occurred and changes the appointment from "Pending" to "Met." If several forms have been filled out for a patient during their visit to the clinic, the first date that meets the status change criteria should be recorded in the system. This will inevitably be driven by the order the forms are keyed into the IQCare. The type of form that was used to change the status should be recorded.	Adult Pharmacy • Dispensed by date Pediatric Pharmacy • Dispensed by date Laboratory • Reported by date Follow up • Visit date Home Visit • First week date
Missed	Definition: A patient did not attend an appointment including the time of the grace period range. Update Process: To detect Missed appointments, the system should run an automated status verification script. Patients that do not meet their appointment within the grace period will have their appointment status changed from "Pending" to "Missed" .	Initial Evaluation • Visit date Follow up • Visit date
Previously Missed	Definition: A patient has missed an appointment and a new appointment is made and is pending. Update Process: If an appointment is missed and a new follow up appointment has been created, then the current appointment is now pending and the missed appointment status changes to "Previously Missed."	Follow up • Visit date
Care Ended	Definition: A patient did not attend an appointment because care has ended. Update Process: For patients that have missed their appointment and	Contact Tracking • Date of Last Actual Contact

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	have a Care Ended form filled in indicating that care has ended, then their appointment status change from “Missed” to “Care Ended.” If a patient has been re-activated, then all of their Care-Ended status appointments should be re-assigned to “Missed”.	

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Part

4 Configuration and Administration

Before you can use IQCare at a facility, the system must be configured to meet the specific location requirements of that location. For example the country and name of the facility, employee list, village, district and province list must be entered into the tool before it can be effectively used. This location specific information/configuration is done via the Administration component of the application. The administration features are found under the Administration link in the top level navigation.

Your facility should designate one or more people to be an IQCare Administrator. This individual oversees the initial configuration and can make changes over time to the various customizable lists and fields. The IQCare Administrator can access all parts of the application.

This section includes:
- Facility/Satellite set up
- Configuring custom lists
- Drug configuration
- Lab order configuration
- User group administration
- User administration
- Configuring custom fields
- Exporting data
- Backing up and restoring the database

4.1 Product Configuration/Facility Set up

IQCare can be configured to display and use the HIV Care Static set of forms or the forms that you have configured for other technical areas. Upon starting the application after the files have been installed on your machine, IQCare will require you to select which set up your facility will be using. Once you have selected which set up you would like you can not re-configure the software. This configuration process is only done once in the lifetime of the product.

4.1.1 Initial Product Configuration

1. After all of the IQCare files have been installed and the IQCare database set up, open a web browser and type in the address
   - Standalone machine: http://127.0.0.1/iqcare/frmlogin.aspx (note that 127.0.0.1 is the internet protocol or IP of your local machine, sometimes called the localhost.
   - Networked machine: http://serverip/iqcare/frmlogin.aspx (note the serverip IP address of the server machine and type it into this URL)
2. For the HIV Care Static set of forms, select IQCare

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3. The Facility/Satellite page will display.

HIV Care Static Form Set

- If this is a completely new installation of an electronic data capture system at a clinic, then the IQCare database is considered “empty” and contains no facility or patient data. In this case the Facility/Satellite page will be empty and you will be required to add the primary facility in order to move to the next step.
- If there has been a data migration from another application to the HIV Care Static Forms, then one or more facilities will display in the Facility/Satellite page.

4. Next, either find the primary facility from the list provided by clicking on the name of the facility, or add a new facility by clicking on the Add button.

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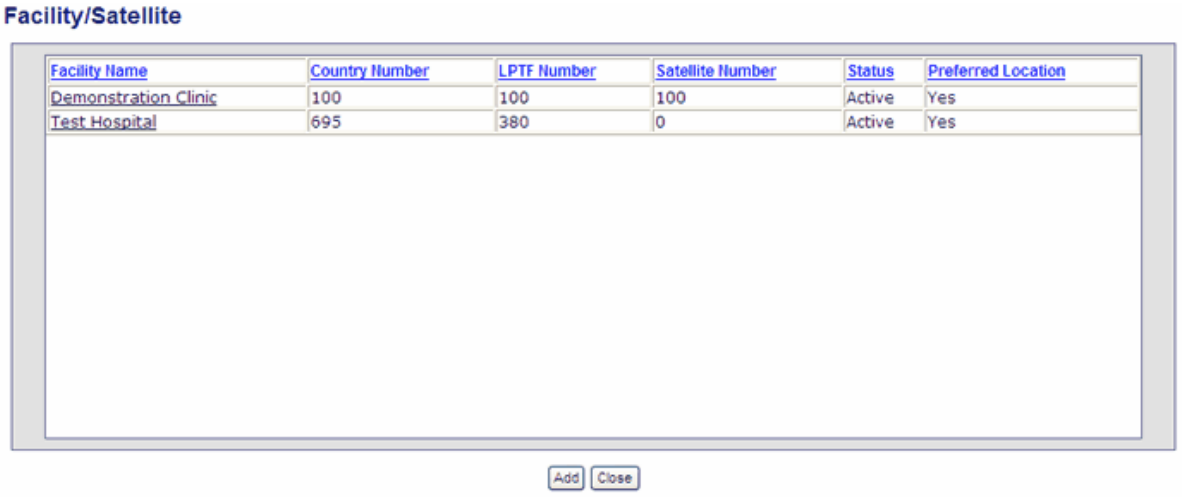
5. Fill in the fields in the fields for the new facility or edit the existing fields for an existing facility. More information about the fields in the Facility Set up page.
6. Click the Save button to save the information.



7. Click Close to return to the Facility Home Page. From the Administration navigation, select Refresh Systems Cache. This updates any new information you have entered for each facility.
8. Click Log out to close the application and log in with the location for which you want to enter data. Note that the locations that were set as a Preferred Location are displayed in the location select list when the Preferred Location check box is check.

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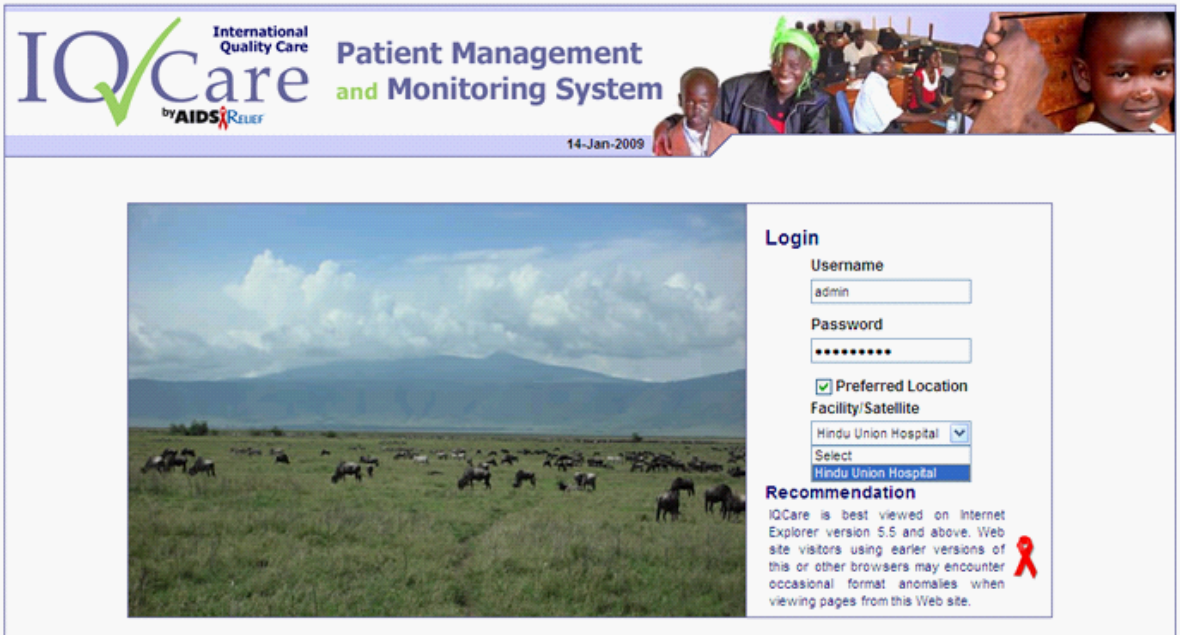

4.1.2 Facility/Satellite Page Field Details

Each location has its own Facility Set up page, requiring each facility or satellite to define variables such as the grace period, and PEPFAR start date. This list of facilities and the information in each facility set up page is responsible for supplying information for the patient number and the treatment location.

The Facility/Satellite list of locations is used in:

- Log in page
- Facility Home Page
- Find/Add Patient
- Transfer Patient Form
- Custom Reports
- IQTools Reports

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Facility/Satellite Name:

- Is the name of the facility and displays in the IQCare header. The maximum length is 50 characters and the name will wrap to the second line after 33 characters.

National Id:

- The national ID number given to a facility by the country ministry of health.

Country number, LPTF number, Satellite number:

- Are the identifying numbers for the clinic and any of its satellites
- Leading zeros are allowed and will be displayed. IQCare converts any numbers with leading zeros into a number. For example: 0001 is saved in IQCare as the number 1, but displayed as 0001.
- Once a facility has been set up and saved, the Country ID, LPTF ID, Sat ID (HIV Care Static Forms numbering series) can not be changed if there is one or more active patients using those numbers. In particular if a location number (ID) is required to be changed, all of the active patients from the changing location must be transferred to another location first.

Province/State

- The province or state where the facility is located.
- This is used in some MOH reports

District

- The district where the facility is located.
- This is used in some MOH reports

Facility login image:

- Is the image that displays in the login page. Note that the login image can be changed from any of Facility Set up pages. The image is not specific to each location; rather, there is only one login image for the application. However, you can change it in any of the Facility Setup pages.
- Please note that the login image should be optimized for the web and the image resolution should be optimized for 72 dpi (pixels per inch). The image size should have a width of 500

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pixels and a height of 300 pixels. Higher image resolution will cause the login page to display slowly; an incorrect image size will cause the image to be distorted.

Appointment grace period:
- Specifies the number of days for which a patient can be either early or late for his/her appointment for it to be classified as a missed appointment. The number of days is facility specific.

PEPFAR funding start date:
- Is the start for the AIDSRelief program at the site
- This is also used to show that a site is an active AIDSRelief site. Patient transferring from a site that has the PEPFAR funding date filled in (and active AR site) to another site that has the PEPFAR funding date filled in (another AR site), then the patient is considered to be transferring in within the AIDSRelief system. Patients transferring from one AR site to another are is not counted as a "transferred in" patient in the Track 1.0 report.

Currency (Country):
- The currency field is directly tied to the country of the facility where IQCare is installed. Any country specific setting are driven off of the currency selection.
- Any country specific variables such as the MOH Reports or PMTCT country specific register forms, use this currency field to identify the country. For example, if you set up the facility with Ugandan Shillings, the Ugandan MOH report and PMTCT register forms will display. Other country specific forms other than from Uganda will not display.

Preferred Location:
- Tags the facility so that it displays as a preferred location in some facility select lists, such as in the Log In page.

Paperless Location:
- Tags the facility so that the paperless business rules will apply to certain forms.

Program:
- Specifies one or more programs that are used for data entry in the system.

Status:
- Determines if the location is active or inactive. Inactive locations do not have any patients associated with them. Furthermore, inactive locations can not be selected as a patient location in the Enrollment form.

4.1.3 Add a Location

1. From the facility level navigation, select Administration and Facility Setup
2. Click the Add button

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3. Fill in all of the fields
4. Click Save. The new location will be displayed in the list of locations

Note that when you add a new facility you must Refresh the System Cache to immediately be able to use the facility.

4.1.4 Edit/Inactivate a Location

A location can not be set to "In Active" if there are any patients associated with the location, including dead patients. If there are patients associated with the location, you must transfer them to another location before you can inactivate a location.

If you inactivate a location, that location will not be available for selection as a location in the Enrollment form. However, the location will be available to view statistics in the Facility Home page and you can filter on this location in Custom Reports.

1. From the facility level navigation, select Administration and Facility Setup
2. Find the location you would like to inactivate in the Facility/Satellite location list

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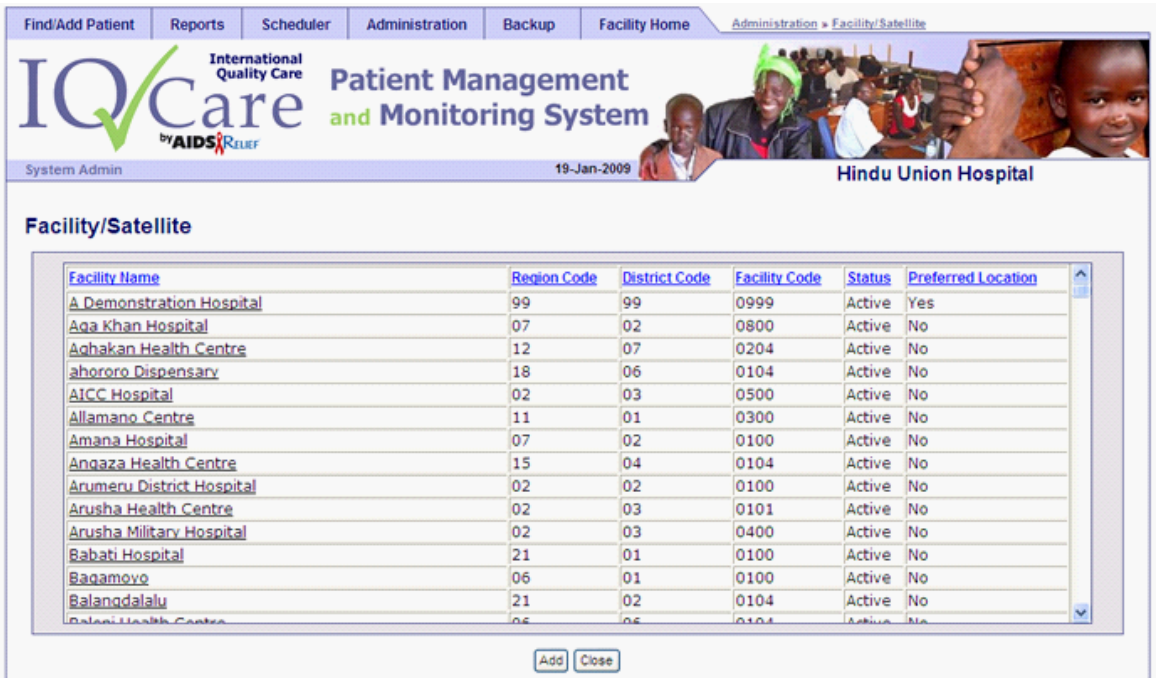
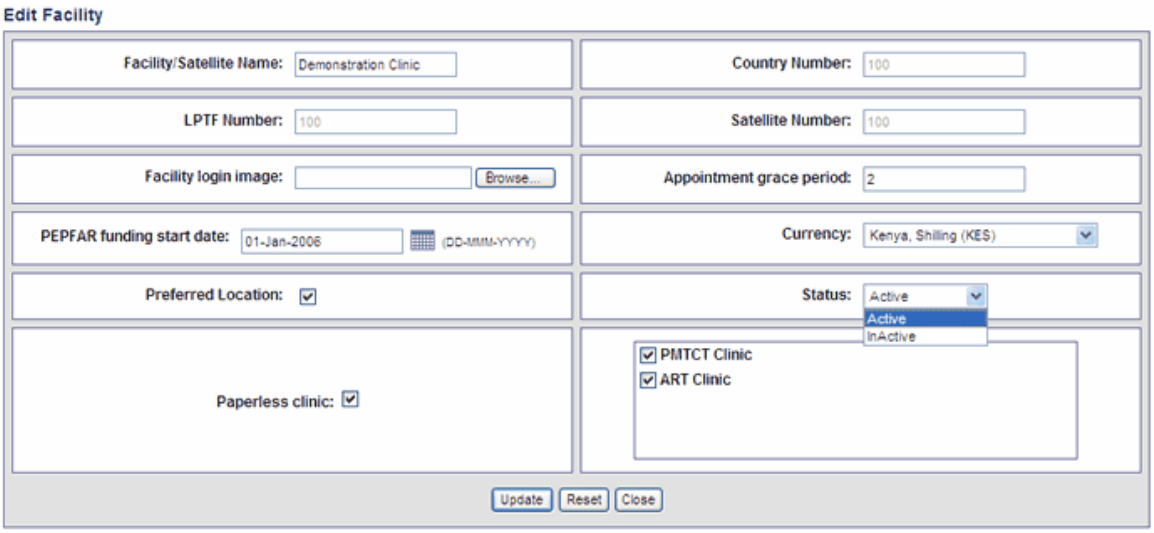


3. Click on the location name, the Facility Setup screen will display
4. Make edits to the fields that are editable or change the status to Inactive



5. Click Update
6. If the location has been set to "In Active", then the location will be removed from the facility list.

Note that when you update an existing facility you must Refresh the System Cache to apply the changes correctly.

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4.1.5 Facility Setup and Patient Number

For HIV Care patients - the following applies:

A patient is given one or more patient numbers depending on the program and the country. When a patient receives services, IQCare tracks the location where the service was given. If the patient moves to another location, you can query the various locations where the patient received services.

IQCare uses these definitions to describe locations within the application.

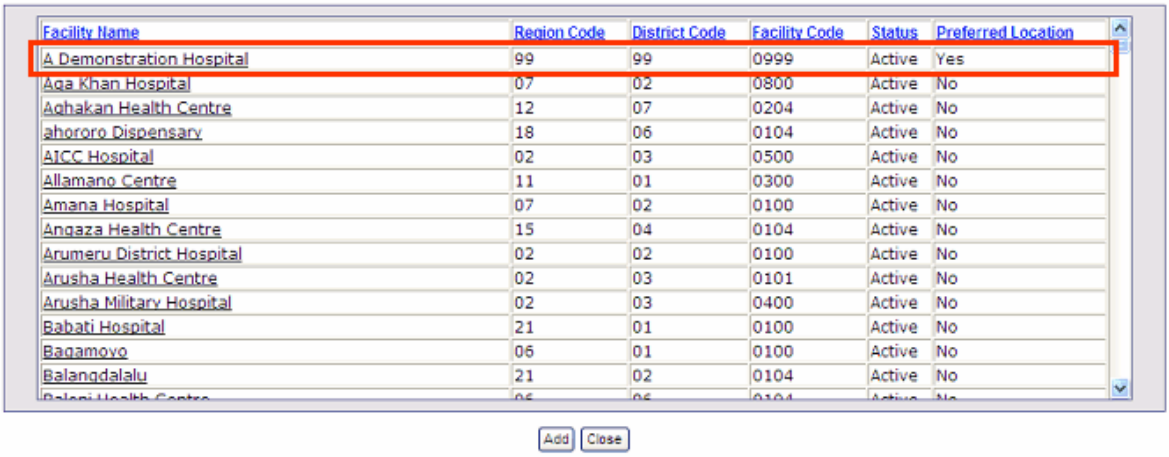
- **Location** = main location or satellites - defined in the Satellite/Facility Set up page
- **Logged-in Location** = the location you logged in with
- **Patient Location** = location the patient is currently (actively) in
- **Treatment Location** = location the patient receives treatment/services (the location where you filled in any clinical form)

In this example below, in the Facility Setup location list, one of the locations is “A Demonstration Hospital”. The location highlighted below has a Regions code of 99, District code of 99 and a Facility code of 0999.

If the patient that you want to enter data for is in “A Demonstration Hospital” then you must log into this hospital to enter his/her information.

When enrolling a new HIV Care patient, when you open the Enrollment form, you will see the Patient ID already filled in with the region code, district code and facility code as per the Facility Setup. These numbers can not be changed in the enrollment form. The user then enters a Patient enrollment number. The concatenation of these four numbers makes up a unique number for the patient.

Facility/Satellite



Facility Name	Region Code	District Code	Facility Code	Status	Preferred Location
A Demonstration Hospital	99	99	0999	Active	Yes
Aga Khan Hospital	07	02	0800	Active	No
Aghakan Health Centre	12	07	0204	Active	No
ahororo Dispensary	18	06	0104	Active	No
AICC Hospital	02	03	0500	Active	No
Allamano Centre	11	01	0300	Active	No
Amana Hospital	07	02	0100	Active	No
Angaza Health Centre	15	04	0104	Active	No
Arumeru District Hospital	02	02	0100	Active	No
Arusha Health Centre	02	03	0101	Active	No
Arusha Military Hospital	02	03	0400	Active	No
Babati Hospital	21	01	0100	Active	No
Bagamoyo	06	01	0100	Active	No
Balangdalalu	21	02	0104	Active	No

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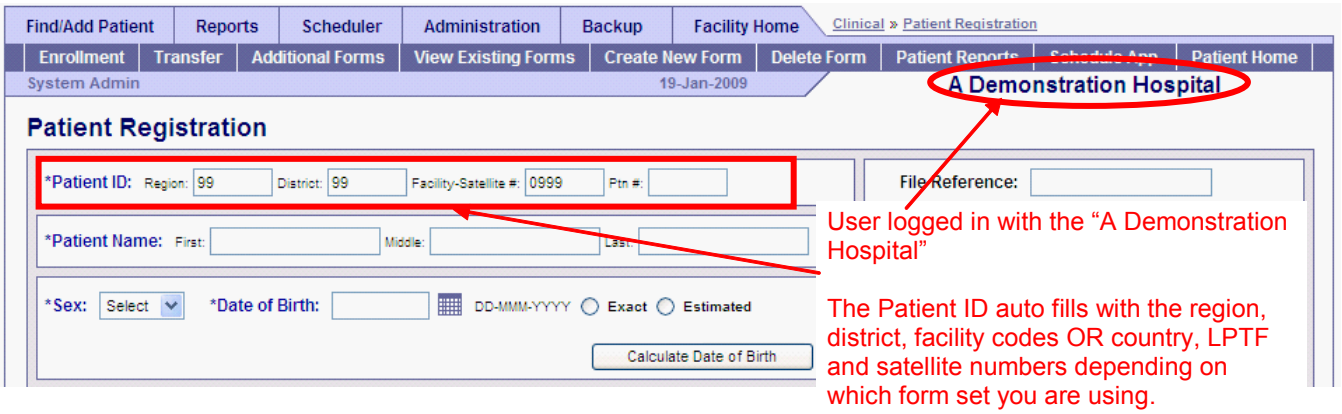
International Quality Care
IQCare
by AIDSRelief
Patient Management and Monitoring System
10-May-2010
IQSolutions
by Futures Group
...Empowering people to make informed decisions
Login
Username
Password
Preferred Location
Facility/Satellite
Select
Login
Recommendation
IQCare is best viewed on Internet Explorer 8 or FireFox 3. Web site visitors using earlier versions of this or other browsers may encounter occasional format anomalies when viewing pages from this web site.
International Quality Care Patient Management and Monitoring System Ver2.4 Copyright © 2006 AIDSRelief. All rights reserved. Release Date: 30-Apr-2010



With the new flexibility of allowing patients to move from one location to another, business rules are required for the patient enrollment number.

1. The IQCare patient ID number is made up of four numbers that are strung together to form a unique number, the Patient ID.
   - HIV Care Static Form set: country number, LPTF number, satellite number, patient number
2. Note that you can have patients with the same patient enrollment number, but with different Patient IDs.
   - For example for the HIV Care Static Form set: 695-134-7-8990 is a different patient than 645-1-3-8990
3. When a patient is enrolled, country, LPTF, Satellite numbers or the region, district, facility codes are not editable within the form. These numbers reflect the location that you logged in with.
4. The patient, once registered, "owns" that patient ID number. If he/she moves to another location, the location number within the patient enrollment number does not change.
5. A variable called the Patient Location holds the current location of a patient. So if a patient is enrolled in location 1 and moves to location 2, their patient number stays the same but their

Patient Location changes.

6. To change the current patient location, you must use a Patient Transfer form.
7. If a patient has been transferred, then in order to enter data for the patient in the new location, you must log into that new location.
8. The patient can not be double counted in two or more locations.
9. The patient status does not change if a satellite location changes. The patient status will remain Active.

Example:

Process Step	AR Patient Number	National Patient Number	Patient Location
Enroll patient	695-134-7-8990	01-02-0101-00089	Location 1 (in this example, Demonstration Clinic)
Transfer patient from location 1 to location 2	695-134-7-8990	01-02-0101-00089	Location 2
Transfer patient from location 2 to location 3	695-134-7-8990	01-02-0101-00089	Location 3
Care end patient (for any reason, including transfer out)	695-134-7-8990	01-02-0101-00089	None

4.1.6 Paperless Facility

In an effort to reduce reproduction and paper costs and increase efficiency, some clinics and hospitals are going “paperless”. By avoiding the use of hardcopy forms, service providers enter information directly into IQCare. IQCare has a number of features that support the paperless facility clinical workflow (see below). These features can be turned on and off by checking the paperless option in Administration--Facility/Satellite configuration for a facility.

Note that when you add a new facility or update an existing facility with the paperless option, you must Refresh the System Cache to avoid getting system errors.

Form/Feature	Hardcopy Process	Paperless Process
e-Signature	The service provider signs his/her name to the bottom of the form.	The service provider selects his/her name in the signature field in the form. Based on the login credentials, only the service provider's name will appear in the select list. This limits people from unintentionally or intentionally using someone else's name in the signature field.
IE, ART and Non-ART Follow up forms	All required fields, in particular, the ARV Therapy plan must be filled in before saving.	The form can be filled out in two steps. The nurse can fill out and save the vitals at triage, before the clinician sees the patient The clinician can fill out the remainder of the form.

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ART and Non-ART Follow up forms	Clinical notes fields are not included because the information is documented in hard copy.	Text fields are added to the ART and Non-ART Follow up forms so that clinicians can keep notes. These notes can be queried using the custom reports.
Adult and Paediatric Pharmacy forms	All of the fields are in a prescription row must be filled in (dose, frequency, duration, quantity prescribed, and quantity dispensed) in order to save the form. Both the ordered by and reported by information must be filled in, in order to save the form.	The pharmacy form can be filled in, in two steps. First the clinician can prescribe the drugs, entering the dose, frequency and quantity prescribed. The clinician can save the form with the Ordered by and Ordered by date filled in. Then the pharmacist can open the form, see the drugs that have been prescribed, enter the amount dispensed and fill in the dispensed by and dispensed by date.
Laboratory	Lab results are entered into a Laboratory form. The ordered by and reported by dates must be filled in, in order to save the form.	A new lab order form has been added to IQCare for the paperless facility. The clinician orders the labs by checking off the labs from a list as well as entering the Ordered by and Ordered by Date. The Lab technician finds the Lab Results form from the View Exiting Forms view for the patient. The labs ordered are highlighted in the form and the lab resulted entered.
View Existing Forms	Forms are either data quality checked (check mark next to form name) or not data quality checked (X mark next to form name).	Both the lab and pharmacy forms can be done in two steps. First there is the order steps completed by the clinician and then the filling of the order (lab results or dispensing drugs) in the second step by the Lab Tech or Pharmacist. To indicate that a form is not completed, a yellow warning icon displays next to the form name. The green check mark and red "X" mark icons also display for those forms that have been data quality checked or not data quality checked respectively.

4.2 Customize Lists

IQCare provides the ability for facilities to change or add entries in many of the select and multi-select lists found within the clinical forms. These select lists are categorized into three areas:

- General - lists that span all programs/treatment areas

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- HIV Care - lists that are specific to the HIV Care program
- PMTCT - lists that are specific to the PMTCT forms

You can modify select and multi-select list in the following ways:

- Add entries
- Update entries
- Prioritize entries
- Inactivate entries

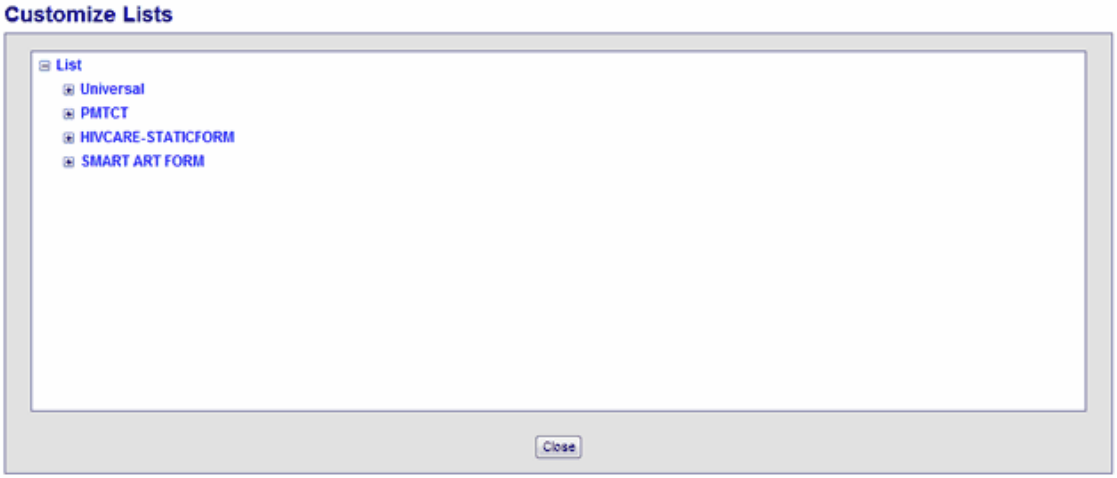
List of HIV Care Custom lists for the HIV Care Static Forms

4.2.1 Pre-defined Custom Lists

▼ Available pre-defined custom lists

There a number of pre-defined custom lists - each relating to technical areas that have been established in IQCare/IQCare Management.

Technical Area	Lists area
Universal	• Select and multi select lists that cross HIV Care and PMTCT • Any new select or multi select list created for a new technical area
HIV Care Static Forms	• List associated with HIV Care static form set
PMTCT	• Lists associated with the pre-defined fields for PMTCT
Smart ART Forms	• Lists associated with the pre-defined fields for HIV Care



▼ Custom lists and technical area activation

- Default lists from pre-defined fields are available to be updated if the technical area has been activated in the Facility Set up page. If the technical has not been activated, then you will see the lock icon next to the list. You can not make updates to lists that are locked.
- If you add a select list via the Form Builder, the newly added list will be available in this section of IQCare for update. The initial list is added via the Form Builder; any changes to the list must be done via the Custom Lists in IQCare.
- List updates behave the same way for all list technical areas lists

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  - Add entries
  - Inactivate entries
  - Change the order/priority of entries
- You can update the pre-defined lists
- You can not remove the default pre-defined lists via the Form Builder or IQCare (they will always be visible)
- You can remove lists you created via the Form Builder

This image shows that the PMTCT pre-defined custom lists are not available for update as per the locked icon. To make these lists available, turn on the PMTCT technical area in the Facility Setup.

▼ Relationship of custom list in IQCare and IQCare Management - Manage Fields

This image shows the PMTCT lists avaialble for updating in IQCare. The same lists can be found in IQCare Management.

This is the PMTCT pre-defined field list in IQCare Management - Manage Fields. The technical area has been filtered for PMTCT. The select lists are designated with an orange dot icon.

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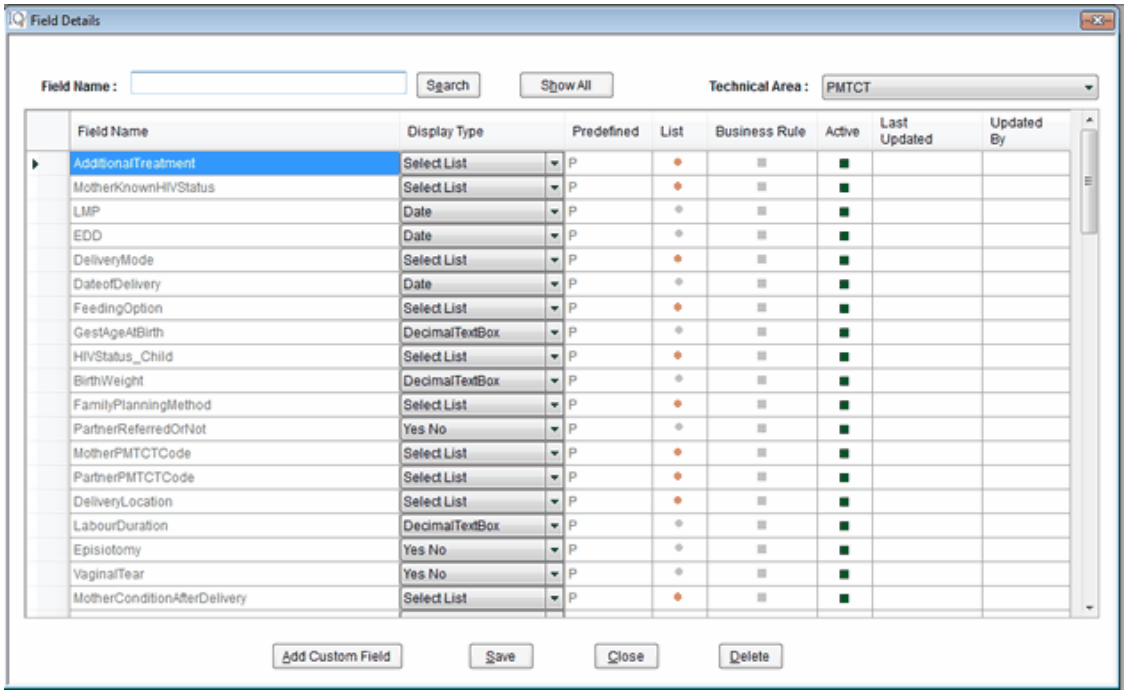

4.2.2 Restricted and Unrestricted Lists

There are two types of select lists available for customization in IQCare – Unrestricted and restricted lists.

Unrestricted lists

- Unrestricted lists are lists that you can change in any way you wish.
- When you install a new instance of IQCare, many of these unrestricted lists are completely empty and must be filled in. For example District, Occupation and Employee

Restricted lists

- Restricted lists do not allow you to change the default entries in any way. However you can add entries to the end of the list and order them as you wish. Examples of restricted lists are ARV Side Effects, OI or AIDS Defining Illnesses and Presenting Complaints.
- Restricted list are for the HIV Care Static form set.
- The lists for pre-defined technical area such as PMTCT and Smart ART forms are all unrestricted lists.

4.2.3 Add an Entry in a Custom List

Adding entries to a custom list has several for

- Unrestricted lists
- Restricted lists
- List with and without codes

1. From the navigation bar, select Customize Lists

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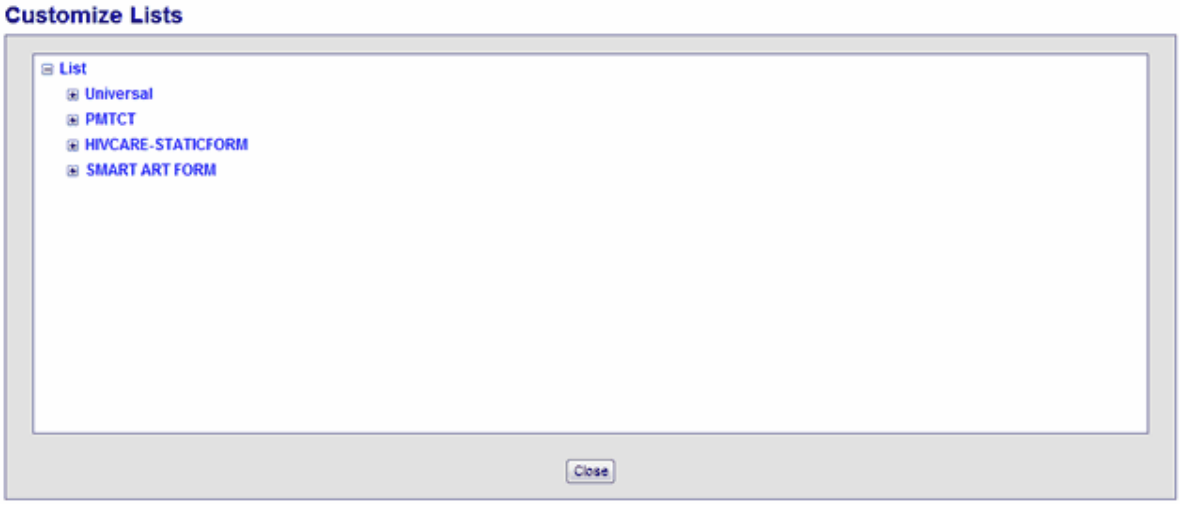
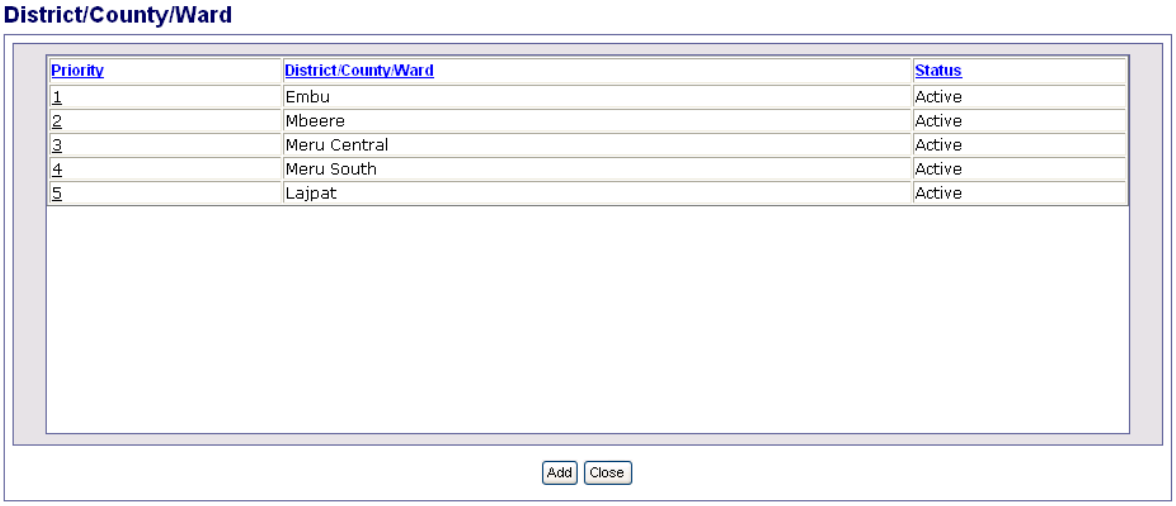
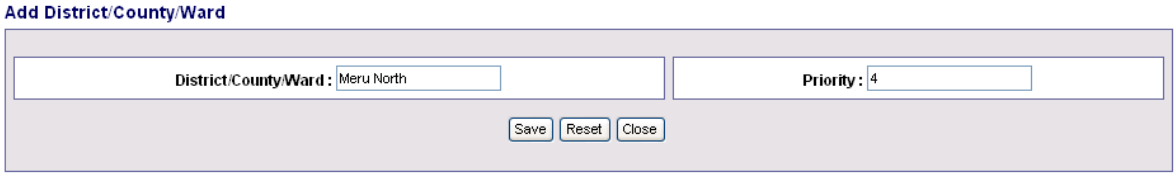


2. Select the list you would like to modify by clicking anywhere in the row with the list information. The list entries will display in a table in priority order.



3. Click the Add button
4. Fill in the list entry name, possibly a code and the priority (note that the entry status is assumed to be “active”). See section on list priorities for more information on how the priorities work.
   - For unrestricted lists, when adding an item, you can add it with the priority you wish.
   - For restricted lists, when adding an item, it will add to the end of the list restricted portion of the list and within the priority specified in the latter section



5. Click Save
6. The new entry will display in the location based on the priority you gave it

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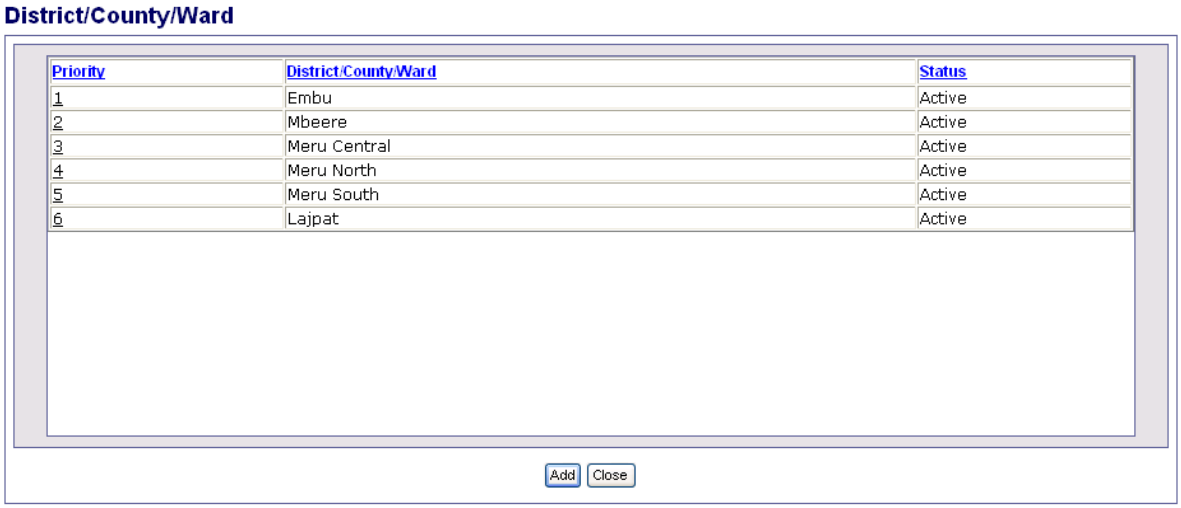
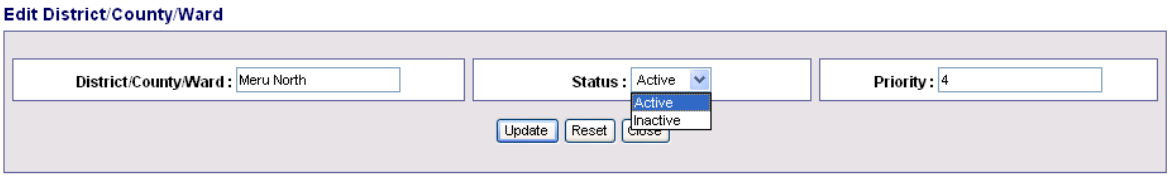


4.2.4 Update an Entry in an Unrestricted Custom List

1. From the navigation bar, select Customize Lists
2. Select the list you would like to modify by clicking anywhere in the row with list name. The selected list displays with the in priority order.
3. Click on the list entry to update. Note that for unrestricted lists, all of the entries can be updated.
4. Change the entry text, the priority or status



5. Click Update
6. The list entry will be updated

4.2.5 Update an Entry in a Restricted Custom List

1. From the navigation bar, select Customize Lists
2. Select the list you would like to modify by clicking anywhere in the row with the list name. The list entries display in a table in priority order.

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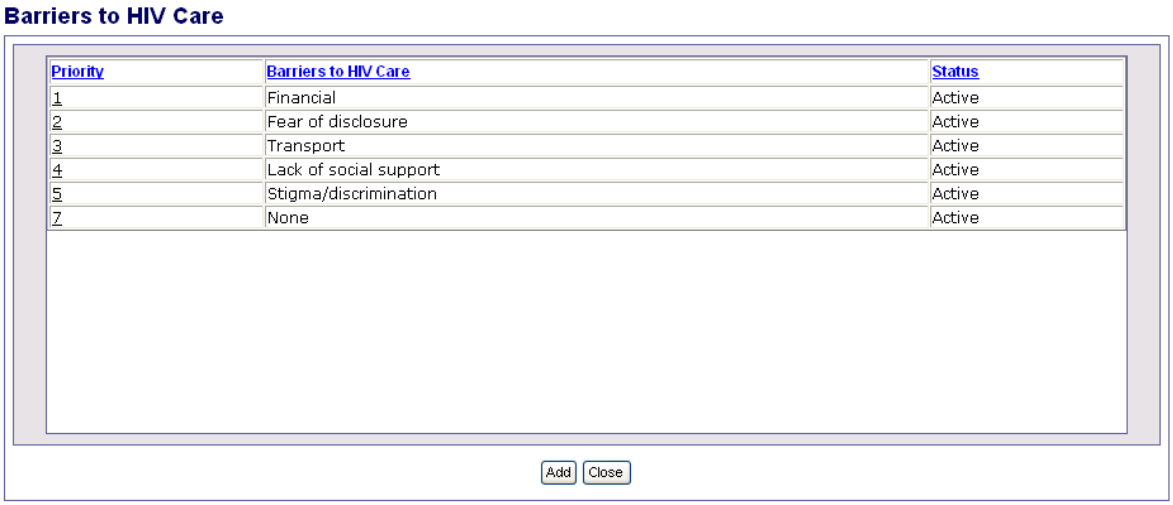
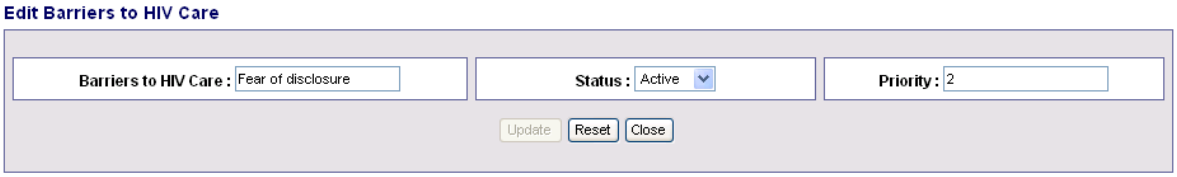


3. Click on the list entry to update. Note that for restricted lists, not all of the entries can be updated as indicated by the grayed-out Update button.



4. All entries added by you that are displayed after the restricted portion of the list can be updated by changing the entry text, status or priority.
5. Click Update
6. The list entry will be updated

4.2.6 Adding Linked List Entries

Some custom lists are linked together so that in the clinical form, if you select an entry in one list, the correct subset of entries display in the second list. An example of this kind linked list is the Follow up Education Counseling Type and Counseling Topic lists . Each Counseling Type has associated with it one or more Counseling Topics. In the example below, the Counseling Type-Counseling Topic custom list allows you to associate Counseling Types with Counseling Topics so that when you select a Counseling Type in the Follow up Education form, only the topics associated with the select Counseling Type display in the select list.

In IQCare linked list are pre-defined and you can add, update and remove entries in these lists. These lists are always named in pairs when setting them up, but may be used individually within forms.

Adding Linked List Entries

1. First make sure the individual lists are correct. Make any updates to each list as per the instructions above.
2. Select the linked list from the list of Custom List.
3. Select an entry in the first list and the list of previously associated entries will display in the lower grid.
4. Select an entry in the second list and click the Add button. A new row will be added to grid

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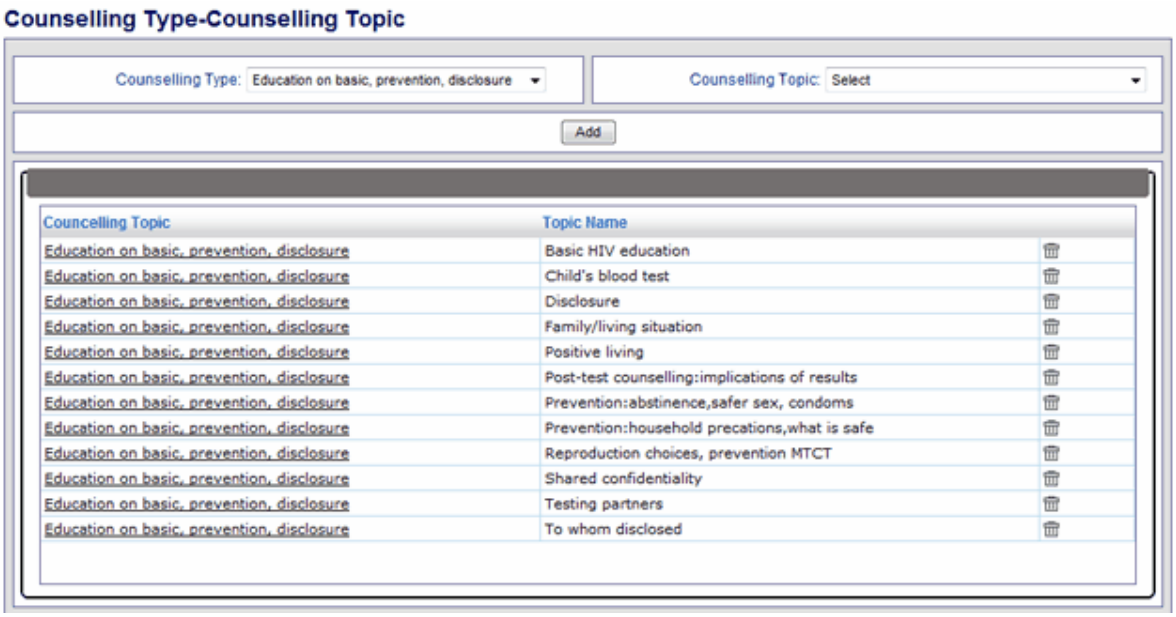

5. Click the Save button to save.

4.2.7 Deleting Linked List Entries

1. From the navigation bar, select Custom Lists
2. Select the linked list you would like to modify
3. Click on the trash can in the row you would like remove
4. Click the Save button to save

4.2.8 Change List Entry Priority

Each list can be arranged so that the select box items display in the form in the order that is best for your facility. Each entry for a select list will have a priority. The higher the number, the farther down the list the list entry will be displayed. You can re-arrange the list entries by giving an entry a new priority number.

For unrestricted lists, you are free to re-arrange all the entries in the list. For restricted lists, the default entries can not be rearranged. However, any entries you add to the end of the restricted lists can be re-arranged.

Changing Priority

1. Note also the number of the location where you wish to move the entry to. For example the entry of “Teacher” should be moved from priority 3 to priority 1.

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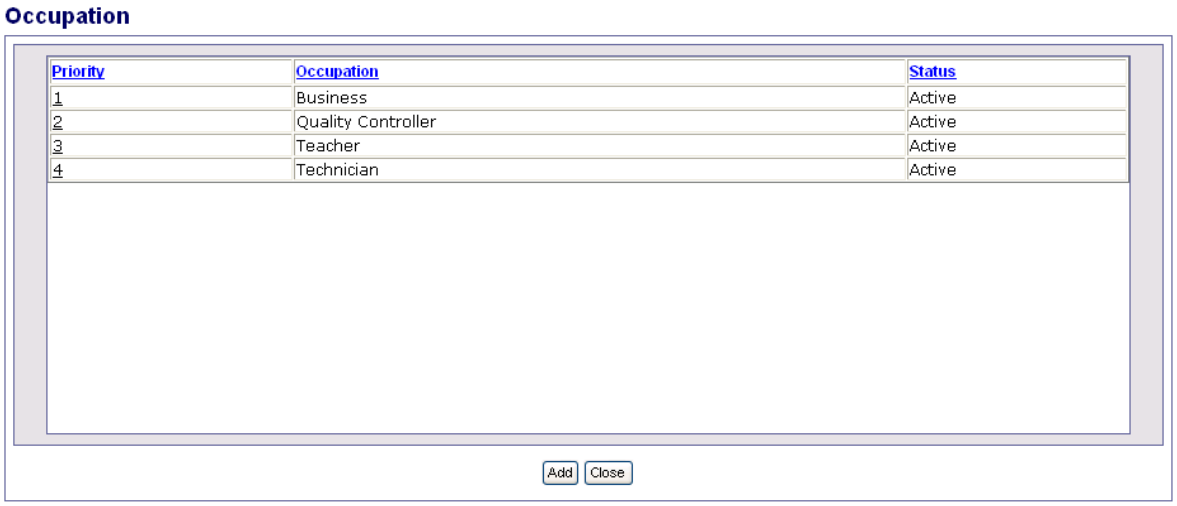
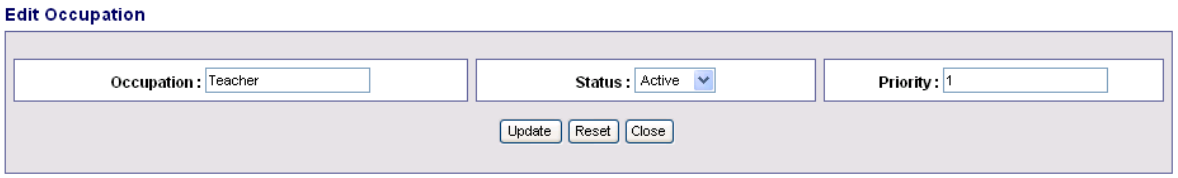
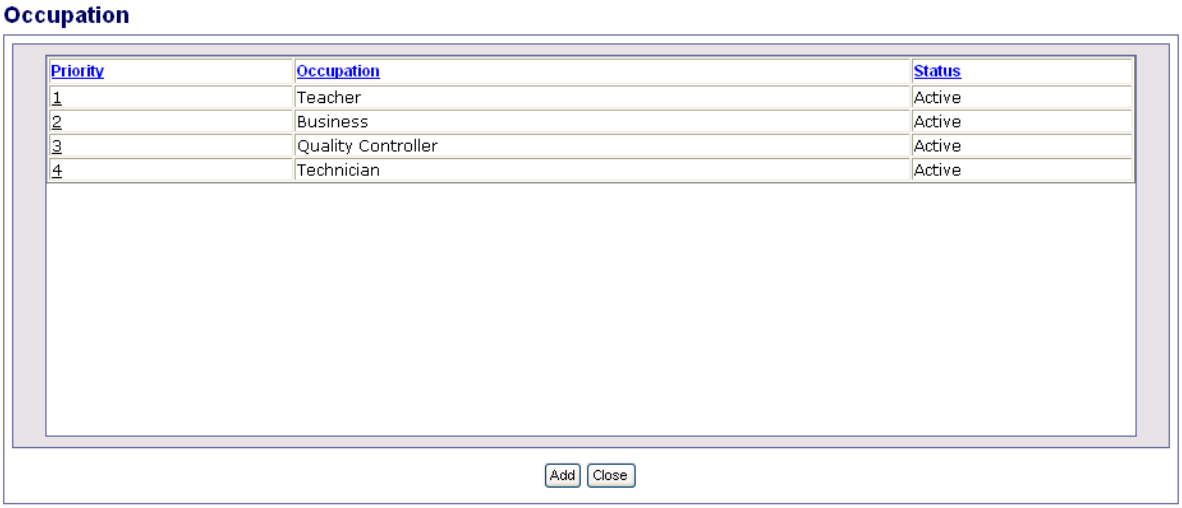


2. Select the list entry
3. Change the priority number to the number where you want the entry to be moved to



4. Click the Updated button
5. Verify that the entry has moved to the new location



6. Repeat as needed

4.2.9 Custom Field Custom Lists

Custom fields in the form of select or multi-select lists can be created from two places within IQCare:

- Configure Custom Fields - Add custom lists
- Form Builder -- Add custom lists

The entry point for the custom field lists may be different, but they work in exactly the same way.

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1. You create a select or multi-select list (either in the custom fields section or the form builder manage field section)
2. You populate the list immediately
3. The lists become available for further update within the Customized Lists section of IQCare

4.3 Drugs Custom List

The drug list found in the Custom List section IQCare allows you to create any trade or generic drug you would like. The drug list is extensive and covers all key drug types. Each drug in the list has a trade name, generic name and strength and is used to in the pharmacy forms and dispensing window.

There is no distinction between drug types. ARV medications are not handled differently from non-ARV medications.

To learn more, see:
Drug relationships/business rules used in IQCare
Add a new drug
Inactivate a drug

4.3.1 Drug Relationships

IQCare has created predefined relationships between drug types, generic and trade names, doses (strength) and frequencies. These relationships for these drug attributes are more constrained for ARV Medications and how you configure ARV medications and non-ARV medications in IQCare is slightly different.

The chart below outlines the underlying rules for how the drug lists work.

Relationship	ARV Medication	Fixed Dose Combination	Non-ARV Medication
A drug can have more than one generic name	No – the generic name must be unique	Yes – more than one generic name makes up the generic name of a FDC– only a trade name can be given to a FDC.	No – the generic name must be unique
A drug can have more than one trade name	Yes – and it is associated with only one generic name	Yes	Yes
A drug can have a generic name without a trade name	No - all drugs must have a trade name. For those drugs with only generic names, enter the generic name in the trade name field	No – the drug is a combination of the generic names that make up the fixed dose combination. There is no separate generic name for FDCs.	Yes
A drug can have an abbreviation	Yes	No – the drug abbreviation is the combination of the generic abbreviations	No

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		tht make up the fixed dose combination	
A drug can have more than one abbreviation	No – the abbreviation must be unique	No	No – the abbreviation must be unique
Each generic name must have an abbreviation	Yes	No	No
There are predefined relationships between a drug type and the available generic names	Yes	Yes	Yes
New generic names can be added	Yes	No	Yes
New trade names can be added	Yes – but must be associate with a generic name	Yes	Yes
New fixed dose combinations can be added		Yes	
Drug strength is pre-determined as part of the drug set up	Yes – all drugs will require strength to be entered at the time of set up	Yes	Yes – all drugs will require strength to be entered at the time of set up
Drug frequency is pre-determined as part of the drug set up	No – will use a separate frequency select list (Pharmacy Frequency).	No	No – will use a separate frequency select list (Pharmacy Frequency)
Drug units is pre-defined as part of the drug set up	Yes	Yes	Yes
Drugs can be removed from the drug list	Yes – their status is changed to Inactive	Yes – their status is changed to Inactive	Yes – their status is changed to Inactive

Every drug is displayed in this combination "Generic name - trade name - strength". For generic drugs, the generic name is entered in place of the trade name, repeating the name.

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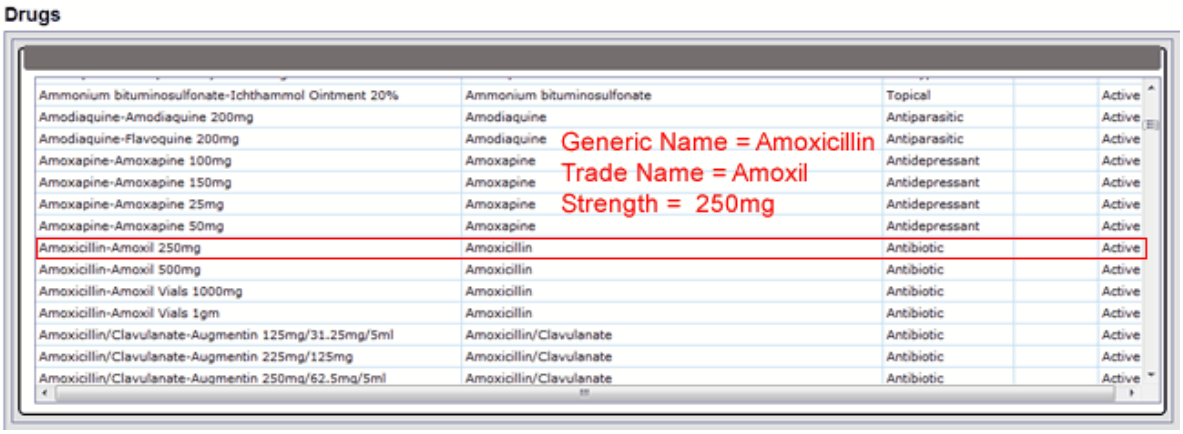


Ammonium bituminosulfonate-Ichthammol Ointment 20%	Ammonium bituminosulfonate	Topical		Active
Amodiaquine-Amodiaquine 200mg	Amodiaquine	Antiparasitic		Active
Amodiaquine-Flavoquine 200mg	Amodiaquine	Antiparasitic		Active
Amoxapine-Amoxapine 100mg	Amoxapine	Antidepressant		Active
Amoxapine-Amoxapine 150mg	Amoxapine	Antidepressant		Active
Amoxapine-Amoxapine 25mg	Amoxapine	Antidepressant		Active
Amoxapine-Amoxapine 50mg	Amoxapine	Antidepressant		Active
Amoxicillin-Amoxil 250mg	Amoxicillin	Antibiotic		Active
Amoxicillin-Amoxil 500mg	Amoxicillin	Antibiotic		Active
Amoxicillin-Amoxil Vials 1000mg	Amoxicillin	Antibiotic		Active
Amoxicillin-Amoxil Vials 1gm	Amoxicillin	Antibiotic		Active
Amoxicillin/Clavulanate-Augmentin 125mg/31.25mg/5ml	Amoxicillin/Clavulanate	Antibiotic		Active
Amoxicillin/Clavulanate-Augmentin 225mg/125mg	Amoxicillin/Clavulanate	Antibiotic		Active
Amoxicillin/Clavulanate-Augmentin 250mg/62.5mg/5ml	Amoxicillin/Clavulanate	Antibiotic		Active

ARV Medication Example:

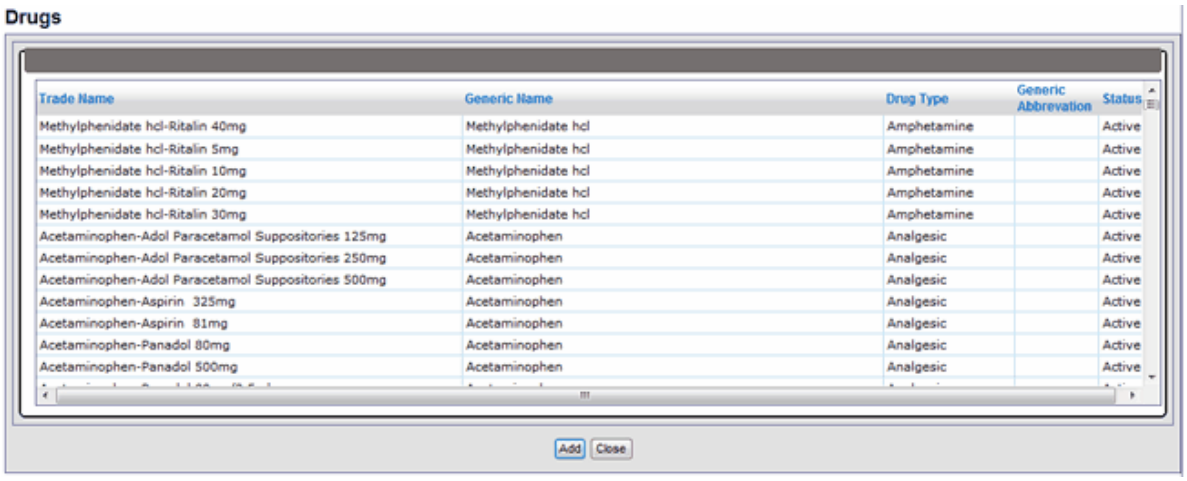
- A drug can have many trade names but only one generic name. For example, for the generic ARV medication Lamivudine, there are 3 trade names – Epivir, Lamvir and Zeffix. As a result you may see a generic name listed several times associated with the many possible trade names.

The list of available drugs within IQCare is displayed in a table, sorted by generic name, in alpha order. To find a trade or generic name, click the column title. Alternatively, use the browser's find in page option and find a drug by searching for the text within the drug list page.

4.3.2 Add a New Drug

In IQCare V3.2 and above, there is no difference between adding an ARV Medication or any other non-ARV medication. Drugs are all handled the same way in the database. Each drug represents a physical item that can be held in inventory for dispensing. Each drug must have a generic name, trade name and strength.

1. Select Customize Lists from the Administration navigation
2. Select Drugs from the table of lists



Trade Name	Generic Name	Drug Type	Generic Abbrevation	Status
Methylphenidate hcl-Ritalin 40mg	Methylphenidate hcl	Amphetamine		Active
Methylphenidate hcl-Ritalin 5mg	Methylphenidate hcl	Amphetamine		Active
Methylphenidate hcl-Ritalin 10mg	Methylphenidate hcl	Amphetamine		Active
Methylphenidate hcl-Ritalin 20mg	Methylphenidate hcl	Amphetamine		Active
Methylphenidate hcl-Ritalin 30mg	Methylphenidate hcl	Amphetamine		Active
Acetaminophen-Adol Paracetamol Suppositories 125mg	Acetaminophen	Analgesic		Active
Acetaminophen-Adol Paracetamol Suppositories 250mg	Acetaminophen	Analgesic		Active
Acetaminophen-Adol Paracetamol Suppositories 500mg	Acetaminophen	Analgesic		Active
Acetaminophen-Aspirin 325mg	Acetaminophen	Analgesic		Active
Acetaminophen-Aspirin 81mg	Acetaminophen	Analgesic		Active
Acetaminophen-Panadol 80mg	Acetaminophen	Analgesic		Active
Acetaminophen-Panadol 500mg	Acetaminophen	Analgesic		Active

3. Click the Add button

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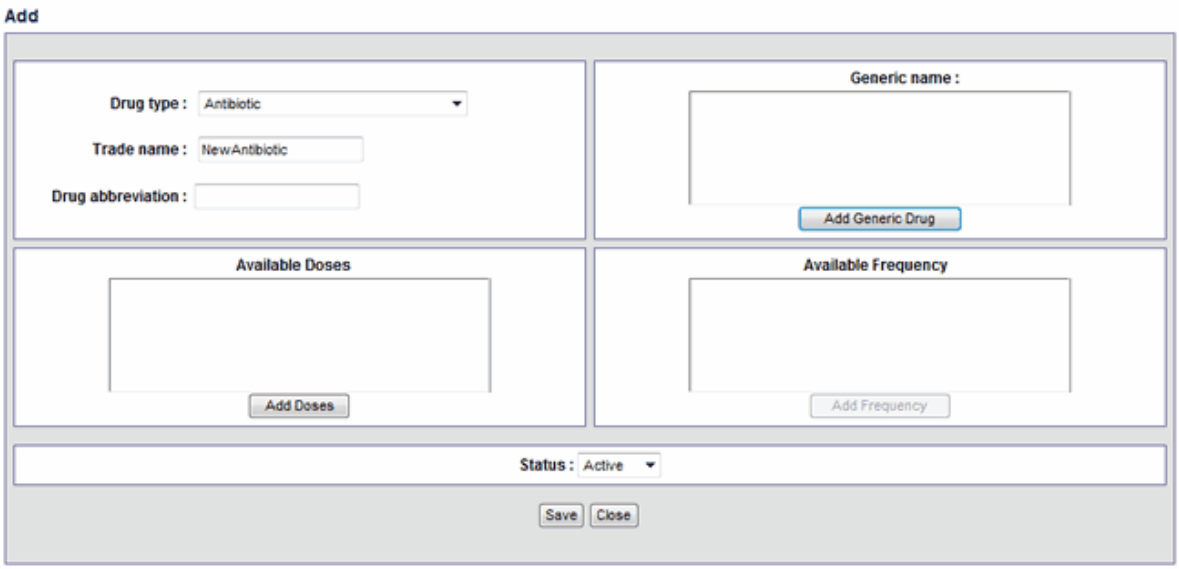
4. Select Drug type and enter a trade name



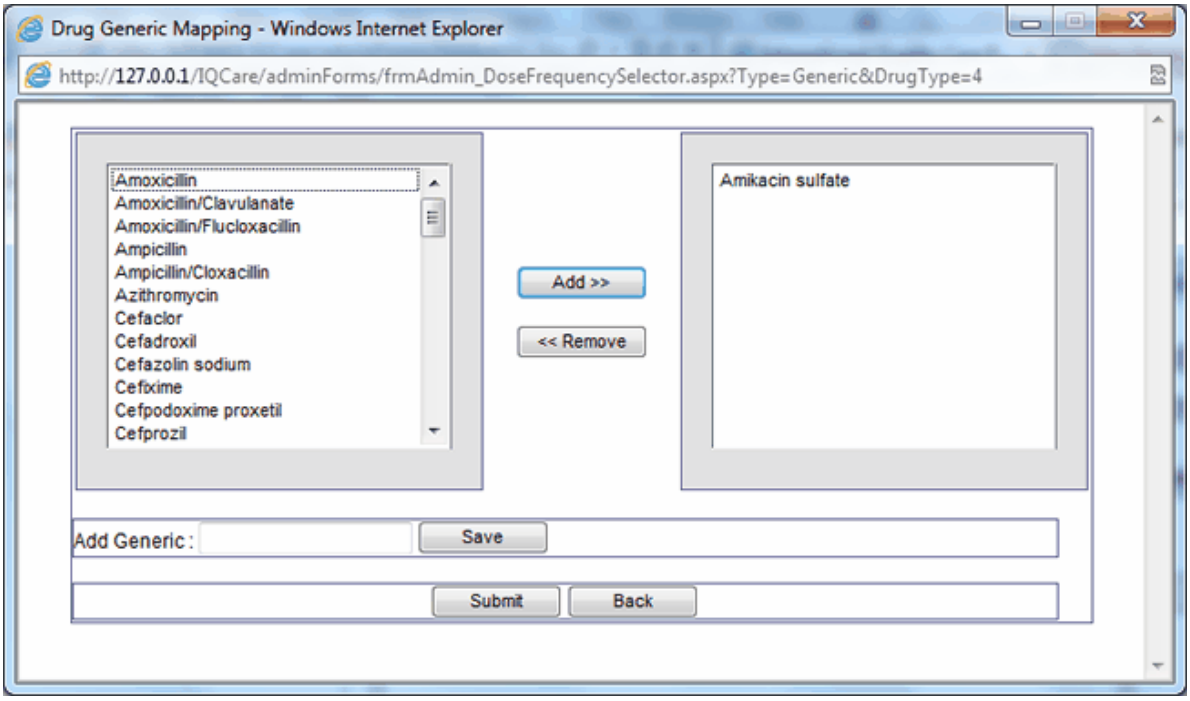
Note that the ability to add frequency has been disabled for 3.2 and above.

.

5. Click Add Generic Drug button

Trade Drug - Associated with one existing generic drug

6. Select the generic name of the drug and using the Add button, move it from the left hand box to the right hand box. If you have selected the wrong generic name, highlight the name on the right side and use the Remove button to put it back into the list.



Trade Drug - Associated with one new generic drug

7. If the generic name for the drug is not in the left hand list, add a new generic name by entering it into

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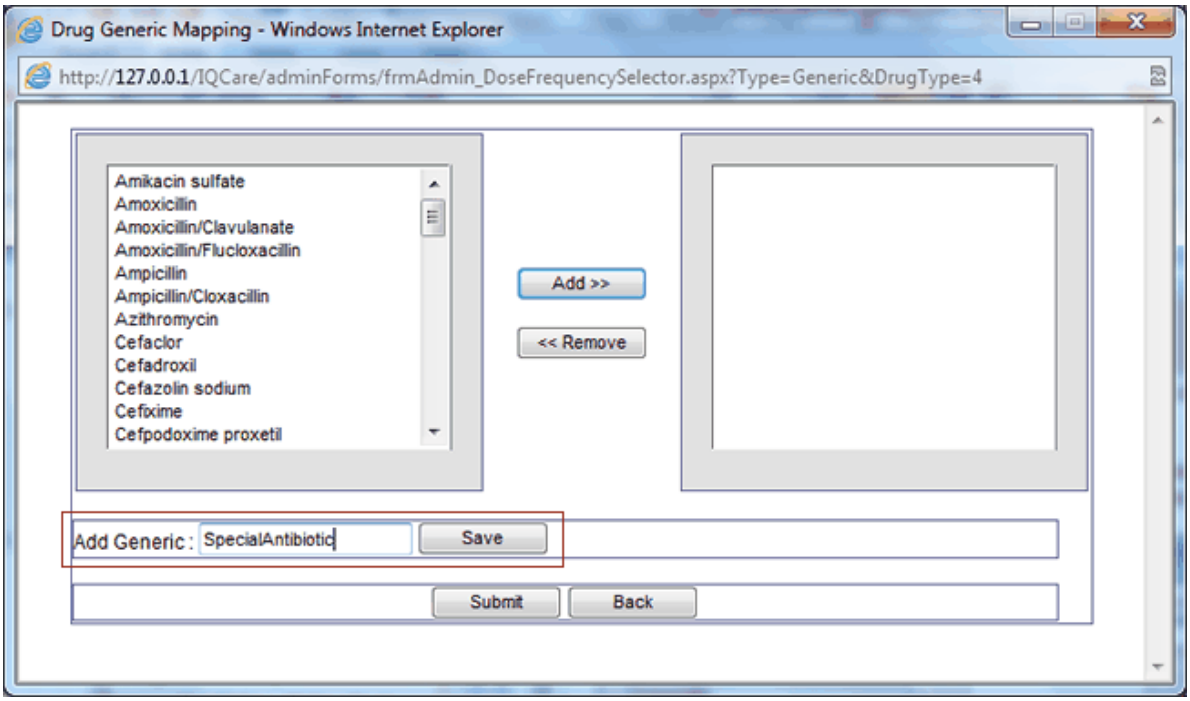
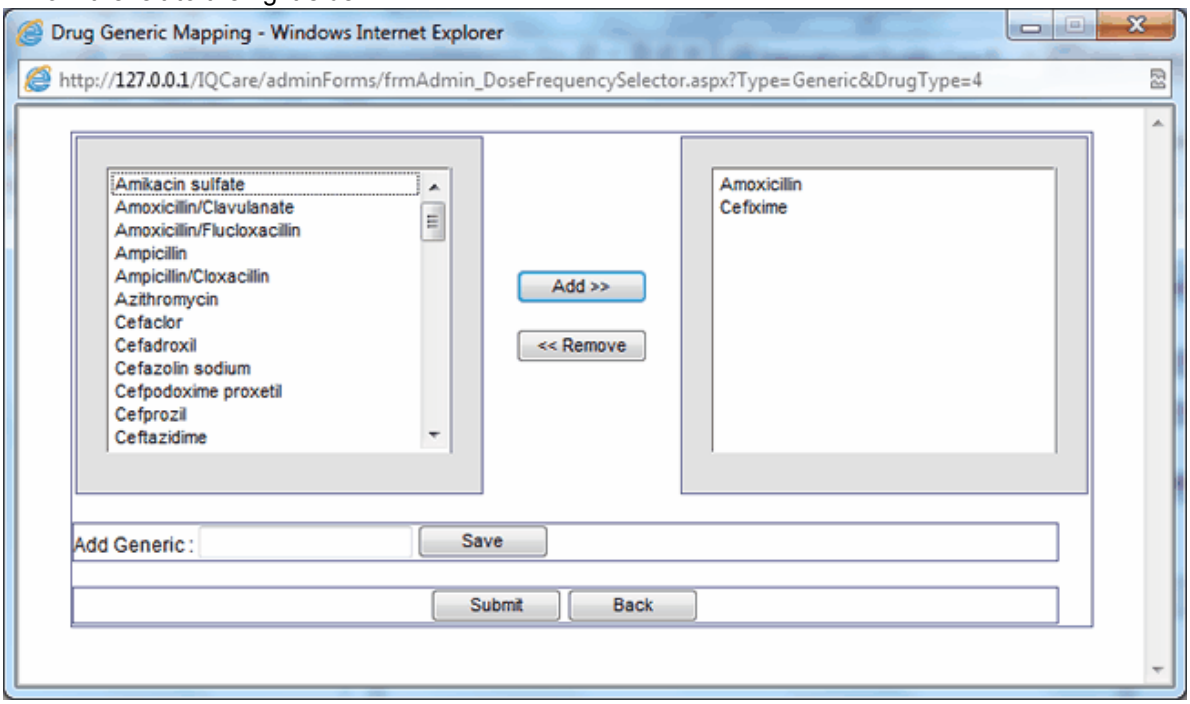
the Add Generic field and click the Save button. This save the new generic name into the list on the left side.



Trade Drug - Associated with more than one generic drug - Fixed Dose Combination

8. If you want to create a fixed dose combination, select more than one generic drug and move them from the left to the right side.



9. Select the generic name of the drug on the left and using the add button move it to the right side.

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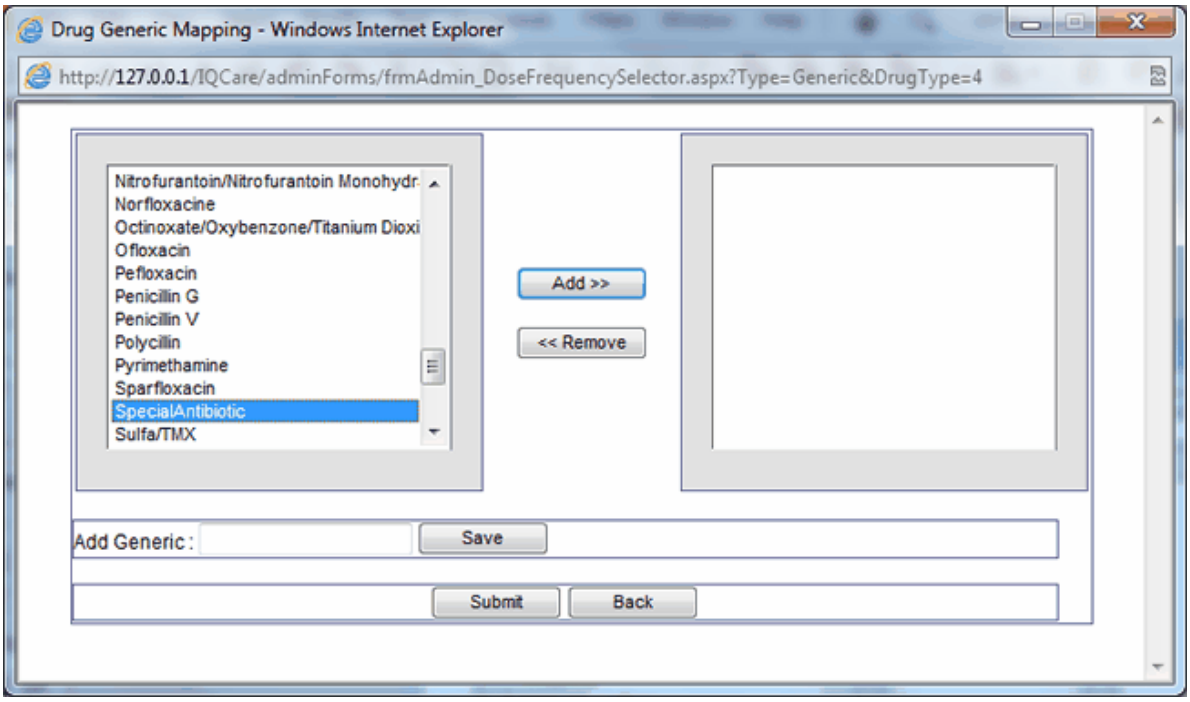
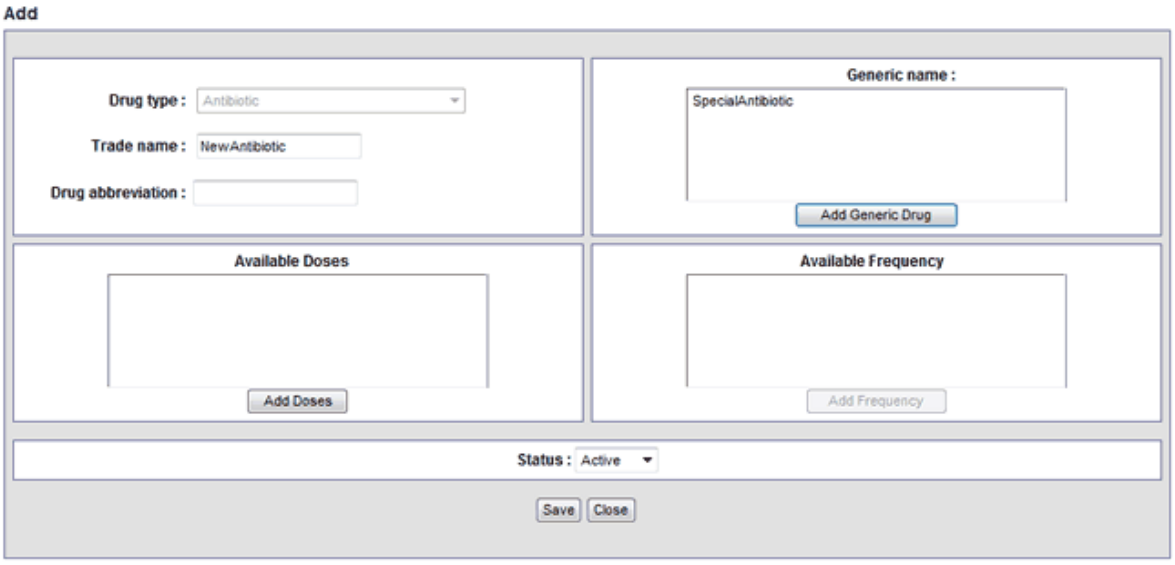


10. Once complete, click Submit



The Drug Type is no longer editable; the generic name displays in the Generic drug box.

11. Add the strength by clicking on the Dose button. A dose picker displays. If you know that a particular drug is available and is dispensed in more than one strength, you can add them all at once. Each strength is saved into the database as a separate row. Each strength is a specific physical item that can be dispensed.
12. Use the vertical scroll bar or simply begin typing in the strength to find the strength. Highlight and use the Add button to select it.
13. Repeat this process until you have found all of the strengths you need. If you do not find the strength, add a new one by entering the new strength in the Add Strength field and clicking Save. This will add the strength to the left hand list. Find the newly created strength and move it to the

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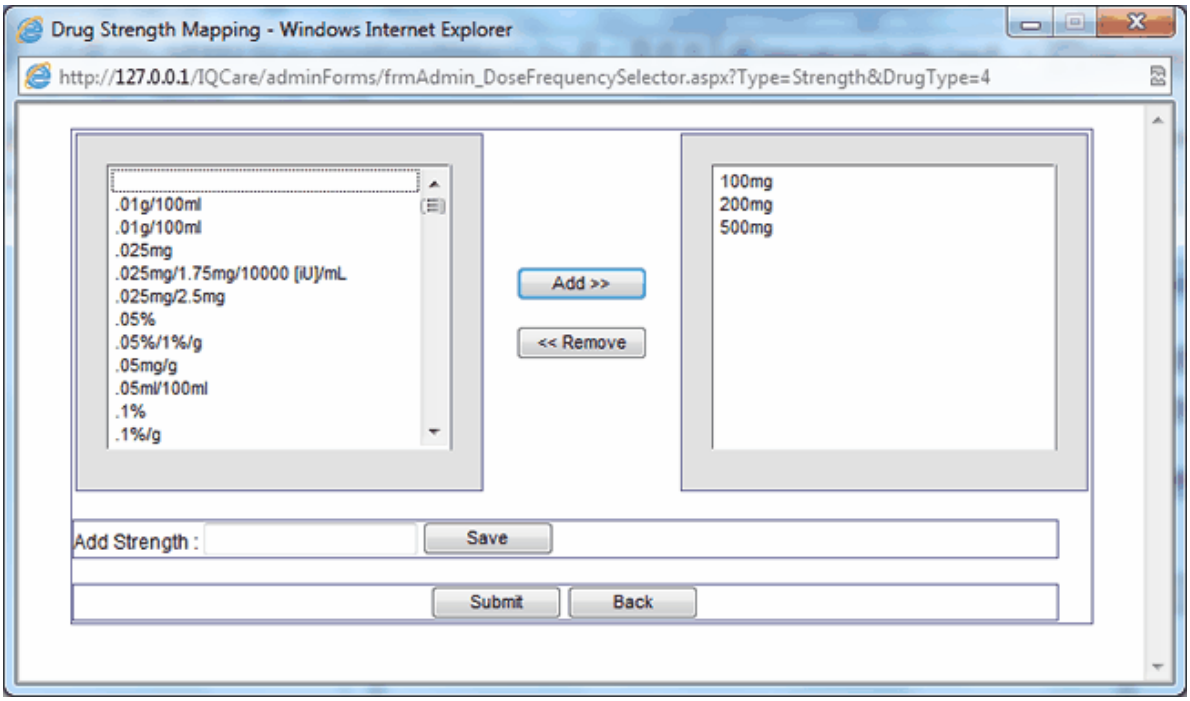
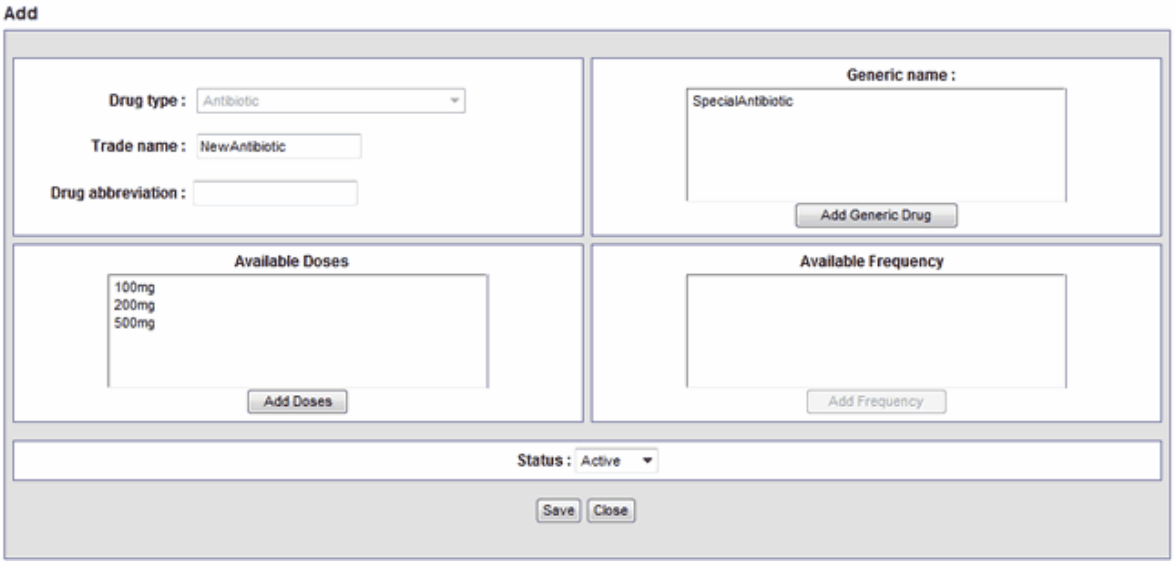
right hand side.



14. When complete, click the Submit button.



15. Click Save to save the new drug
16. The new drug will display in the drug list with a trade and generic name.

- Note also that each strength has been saved in its own row. If you want to make updates, you must update each individual drug at this point going forward.
- Note that once you have saved a drug, you can not edit it. If you have made a mistake, you can inactivate the drug so that it does not get displayed in pharmacy or dispensing forms.

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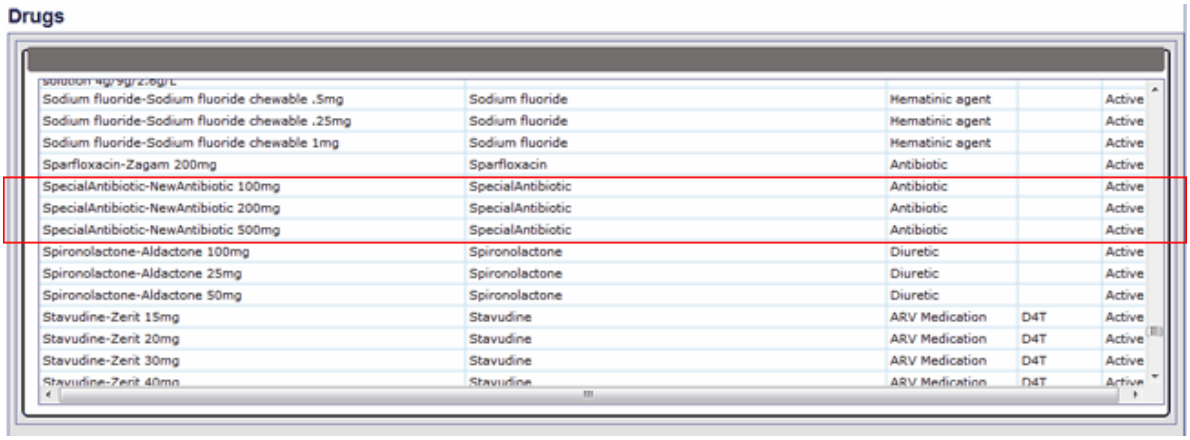
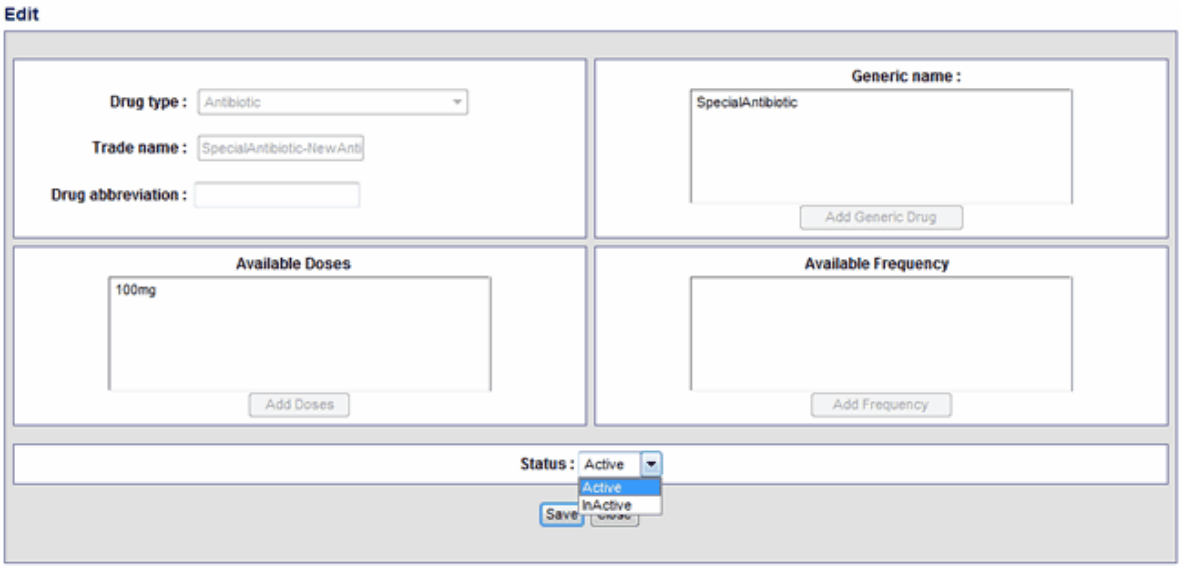

Drugs
Sodium fluoride-Sodium fluoride chewable .5mg Sodium fluoride Hematinic agent Active
Sodium fluoride-Sodium fluoride chewable .25mg Sodium fluoride Hematinic agent Active
Sodium fluoride-Sodium fluoride chewable 1mg Sodium fluoride Hematinic agent Active
Sparfloxacin-Zagam 200mg Sparfloxacin Antibiotic Active
SpecialAntibiotic-NewAntibiotic 100mg SpecialAntibiotic Antibiotic Active
SpecialAntibiotic-NewAntibiotic 200mg SpecialAntibiotic Antibiotic Active
SpecialAntibiotic-NewAntibiotic 500mg SpecialAntibiotic Antibiotic Active
Spironolactone-Aldactone 100mg Spironolactone Diuretic Active
Spironolactone-Aldactone 25mg Spironolactone Diuretic Active
Spironolactone-Aldactone 50mg Spironolactone Diuretic Active
Stavudine-Zerit 15mg Stavudine ARV Medication D4T Active
Stavudine-Zerit 20mg Stavudine ARV Medication D4T Active
Stavudine-Zerit 30mg Stavudine ARV Medication D4T Active

4.3.3 Inactivate a Drug

1. Select Customize Lists from the top level navigation
2. Select Drugs from the table of lists
3. Find and select the drug you wish to change
4. To remove the drug from the list, change the status from Active to Inactive



4.3.4 Using the IQCare Picker Tool

IQCare provides a helper tool that allows you to select items from a list, such as drugs, strength (dose), and frequencies. Every helper tool has two lists – the Available Items and the Selected Items. The steps to add and remove items to and from a list are the same throughout.

Selecting Items from the Available List

1. When the Helper Tool is used, a small window displays that is separate from the main browser window.
2. A list of all of the possible items to select is displayed in the left side of the window; already

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selected items display on the right side of the window.

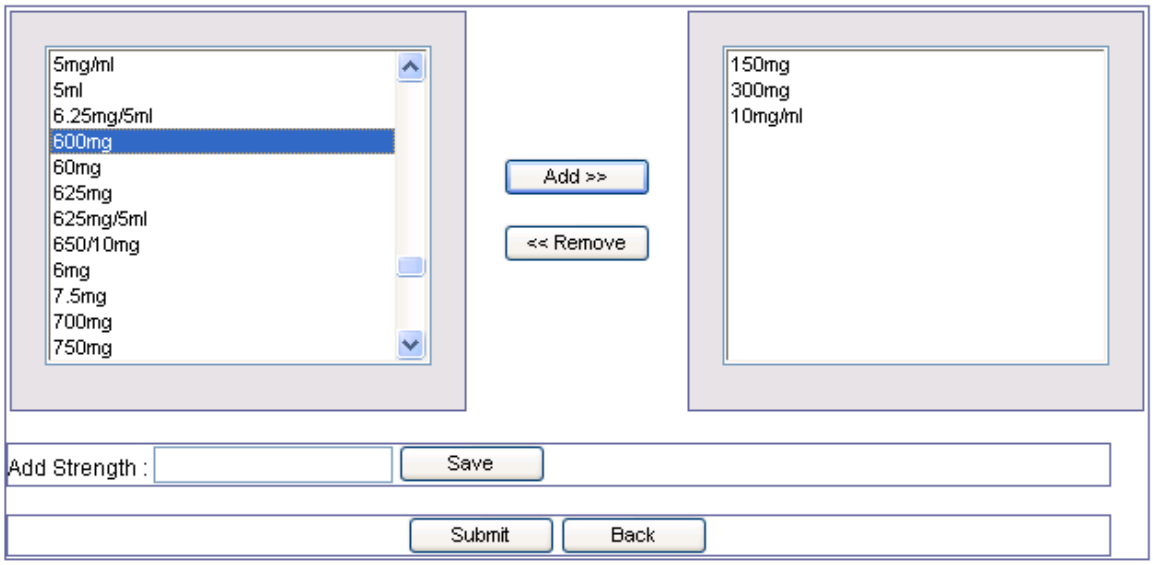
3. To add an item from the available list to the selected list, find the entry on the left side, highlight it and click the Add button to move it to the right side.
   - Note that you can find the item by either scrolling through the list or by typing the first and subsequent letter of the entry you are looking for.
   - Note that by moving an item from the left to the right, the item is removed from the left list altogether, it can not be selected twice.

Removing Entries from the Selected List

4. To remove an item from the Selected list, find the item in the right side, highlight it and click the Remove button to remove it; it is now added back to the Available List.

Adding New Items to the Available List

5. If the entry is not in the Available list on the left, you can add the new item by typing it into the Add field at the bottom of the window. Click the Add button to add the new entry to the Available List on the left side.
6. Now select the newly added item from the list on the left side and move it to the right side.



4.4 Lab Order Form Configuration

Depending on the laboratory machinery used, facilities may report numeric lab test results for particular labs with different units and corresponding lower and upper boundary values. IQCare provides complete flexibility in the units and boundary values for numeric laboratory test results on the Lab Order form. Existing units can be modified or new ones added. In addition, lower and upper boundary values are available for Additional Labs with numeric lab results.

There is an underlying assumption that lab units change very infrequently. If a clinic needs to change the units and boundaries for a particular lab test, the administrator simply changes the default units that are displayed in the lab form. This change must be done in the Lab Order Configuration and can not be done on the Lab Order form directly.

To configure the laboratory order form, follow these steps for each lab test:

1. In the Laboratory Units select list, verify that the lab test unit is in the list. If not, then add the new

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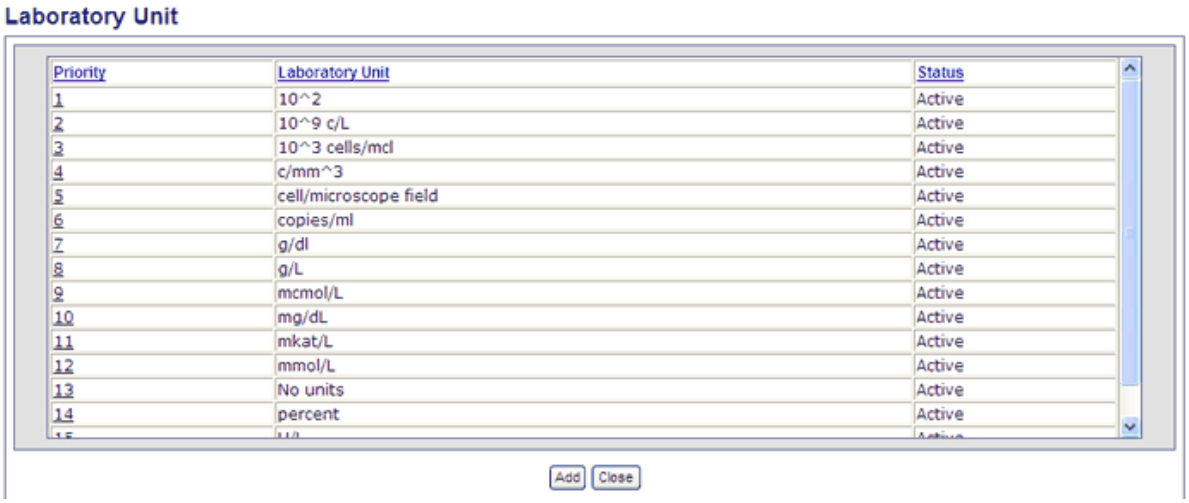
laboratory unit
2. In the Configure Lab Order Form list, find the lab test you want to configure
3. Update the lab test units and boundary values; the units will display in the Lab Order form and the boundary values are used to validate the test result field.

.

4.4.1 Adding a Laboratory Unit

The Laboratory Units list is an unrestricted list. Laboratory Units added in this list are used in the Lab Order Form Configuration. Adding a new Laboratory Unit follows the same process as adding any other custom list. For instructions to add a laboratory unit, see adding Add Entry in a Custom List.



4.4.2 Configuring Lab Units and Boundary Values

The Lab Order Configuration specifies the units and boundary values for each numeric lab test found on the Lab Order form. Changing the default units and boundaries in the Lab Order Configuration will change the units displayed and the field level boundary validation on the Lab Order form.

The lists of lab tests available for configuration are all of the lab tests with numeric values in the Lab Order form. Text and pos/neg result type lab tests are not in this list. Furthermore, you can not add or remove tests from the Lab Order Configuration list.

IQCare comes with a set of default units and boundaries. When you install IQCare at your facility, you should review and verify that the units are correct for your site.

Add a New Unit-Boundary Pair
1. Select Customize Lists from the top level navigation
2. Select Lab Order Configuration from the table of lists

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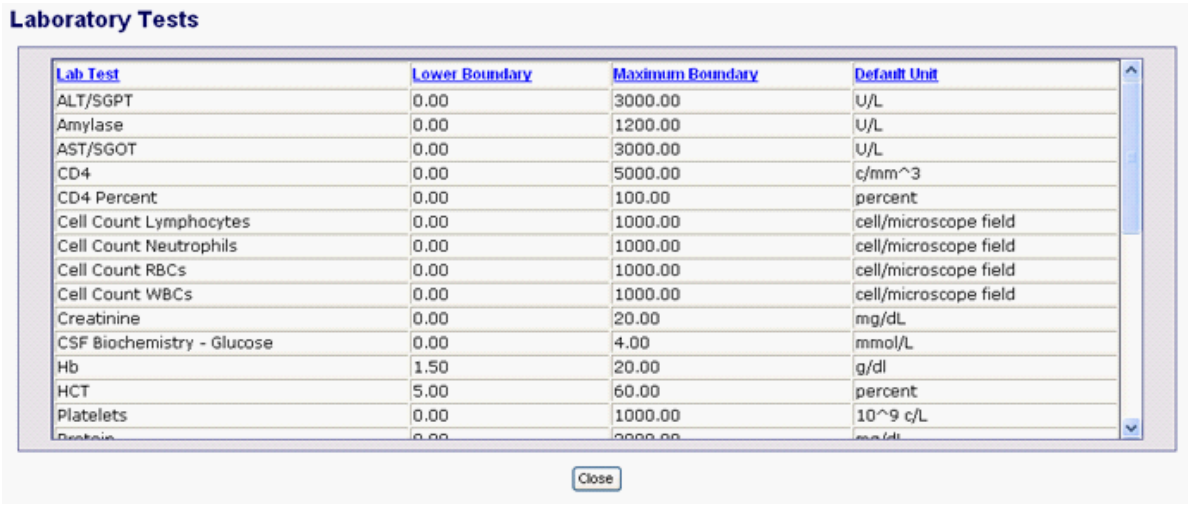
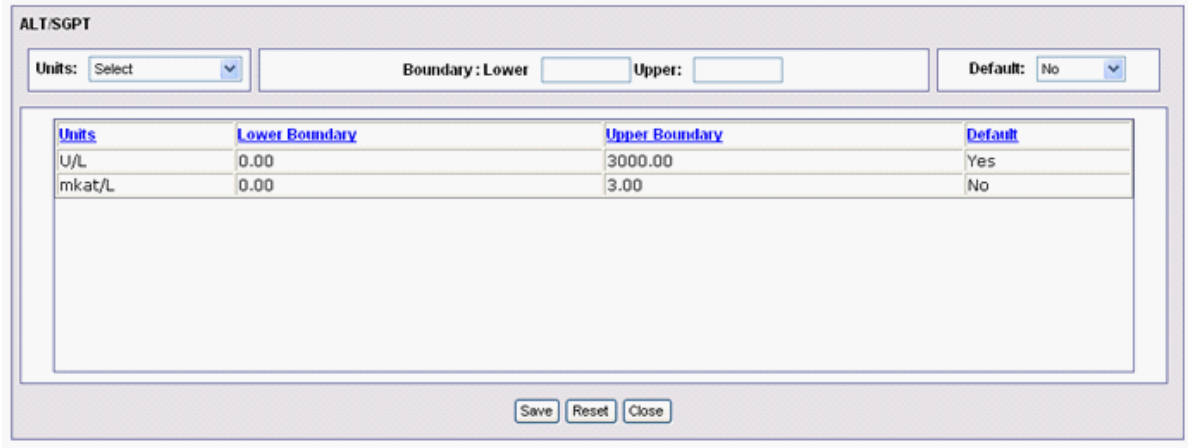
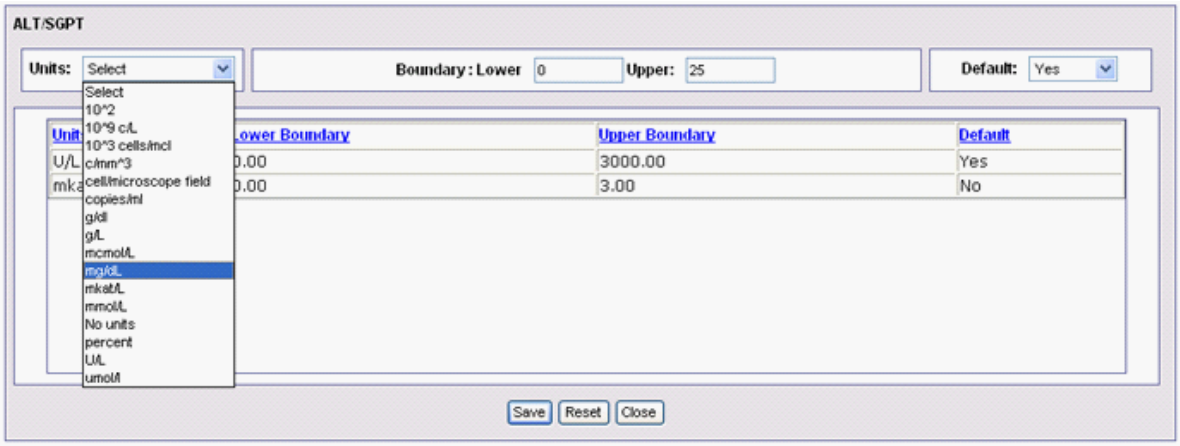

Laboratory Tests
Lab Test
Lower Boundary
Maximum Boundary
Default Unit
ALT/SGPT 0.00 3000.00 U/L
Amylase 0.00 1200.00 U/L
AST/SGOT 0.00 3000.00 U/L
CD4 0.00 5000.00 c/mm^3
CD4 Percent 0.00 100.00 percent
Cell Count Lymphocytes 0.00 1000.00 cell/microscope field
Cell Count Neutrophils 0.00 1000.00 cell/microscope field
Cell Count RBCs 0.00 1000.00 cell/microscope field
Cell Count WBCs 0.00 1000.00 cell/microscope field
Creatinine 0.00 20.00 mg/dL
CSF Biochemistry - Glucose 0.00 4.00 mmol/L
Hb 1.50 20.00 g/dl
HCT 5.00 60.00 percent
Platelets 0.00 1000.00 10^9 c/L
Close

3. Click on the lab test name you want to configure



4. Select the lab units; enter the lower and upper boundary; select “yes” to make this unit-boundary pair the default that will be used in the Lab Order form



5. Click save; the new units are saved and displayed in the grid.

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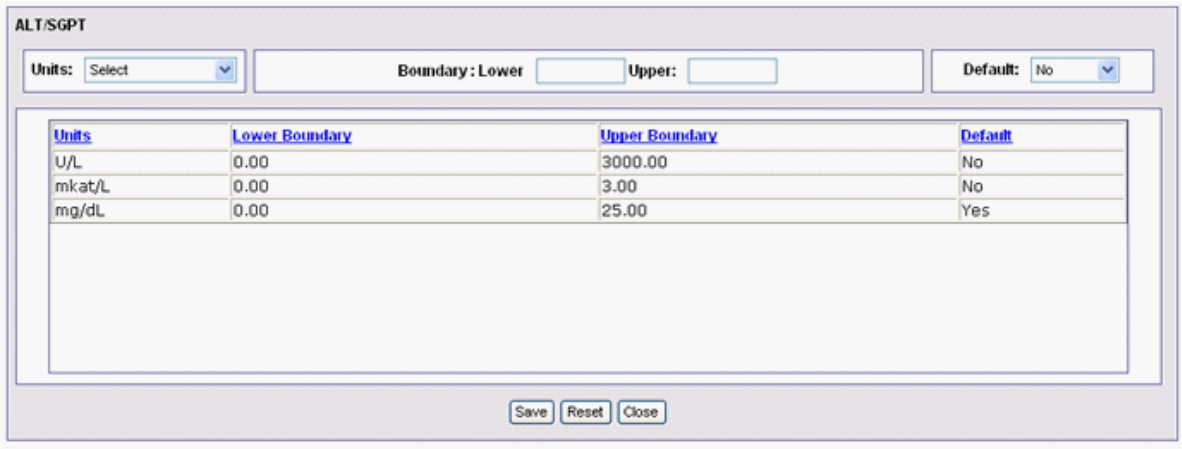
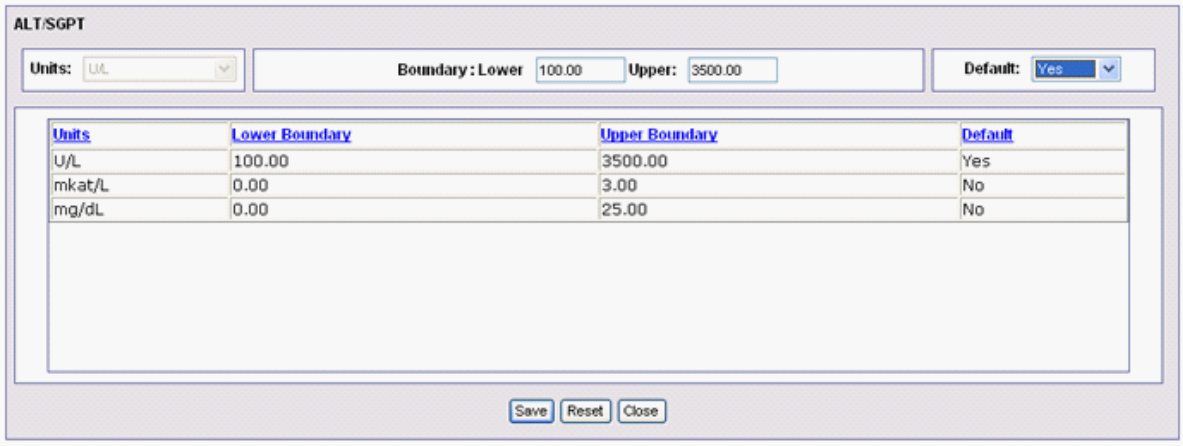


Change Unit Boundaries or Lab Form Defaults

1. Select Customize Lists from the top level navigation
2. Select Lab Order Configuration from the table of lists
3. Click on the lab test name you want to change
4. Click on the units you want to change within the grid displaying all of the previously configured unit-boundary pairs. The lower and upper boundaries and the default indicator displays at the top of the screen.
5. Change the boundaries and/or the default indicator



6. Click Save to save your changes

4.4.3 How Lab Unit Configuration Changes Impact the Lab Order Form

IQCare only saves actual data. That is, if there are blanks spaces in a clinical form, null values (a blank field) are not saved. By saving only actual data, such as numbers and characters, the IQCare database does not grow too quickly and database queries run faster.

For the Lab Order form, lab test results and the associated lab test units are saved into the IQCare database. When you create a new Lab Order form for a patient, the default units you selected in the Lab Configuration are applied to the appropriate lab tests. When you enter information into the Lab

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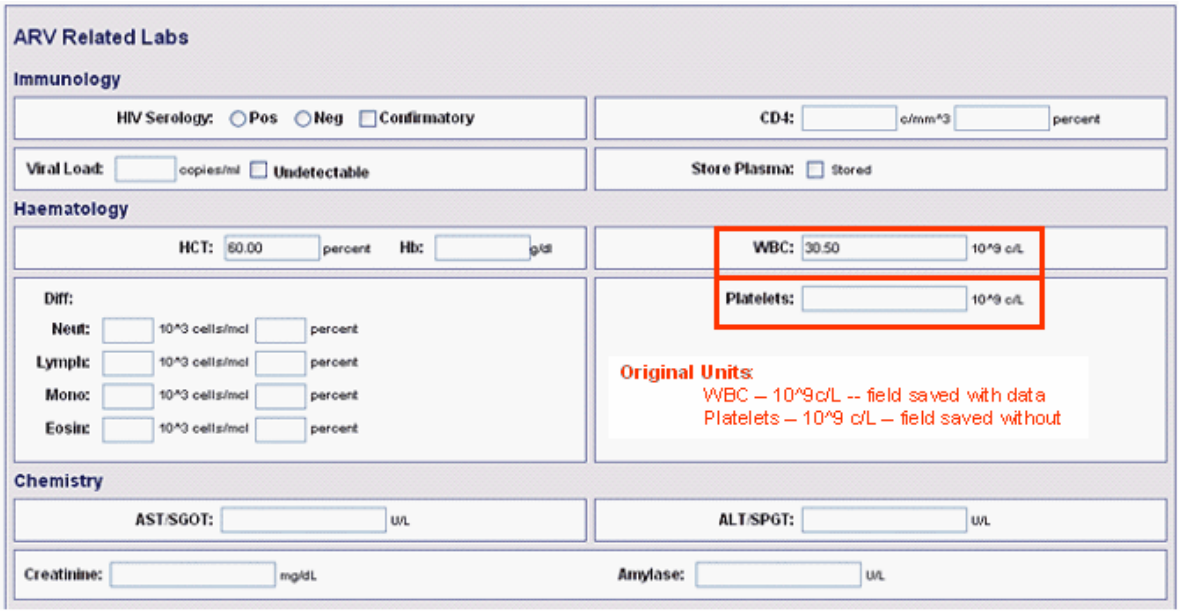
Order form and save, the lab test results and the associated units for the filled in lab test are saved. Now suppose you go back to the Lab Configuration and change a unit for a lab test. If there was data saved for that lab test, then the data and the previous lab unit was saved and will display in the form. If there was no data associated with that changed lab test, and you open an already filled in lab form, the lab units will change to the new default.

Example: WBC and Platelets.
In this example the units for WBC and Platelets are both set to 10^9 c/L. WBC has a lab test result of 30.5.



Now, the User moves to the Lab Configuration and changes the default units for WBC and Platelets to 10^3 cells/mcl. When the previously saved form is pulled up, the WBC result has saved correctly with 30.5 and 10^9 c/L units. The Platelets however did not have data saved and its units have changed to the new default. Because IQCare does not save blanks (nulls) when the application saves a form, IQCare will display the default unit for those fields in previously saved forms that did not have test result data entered.

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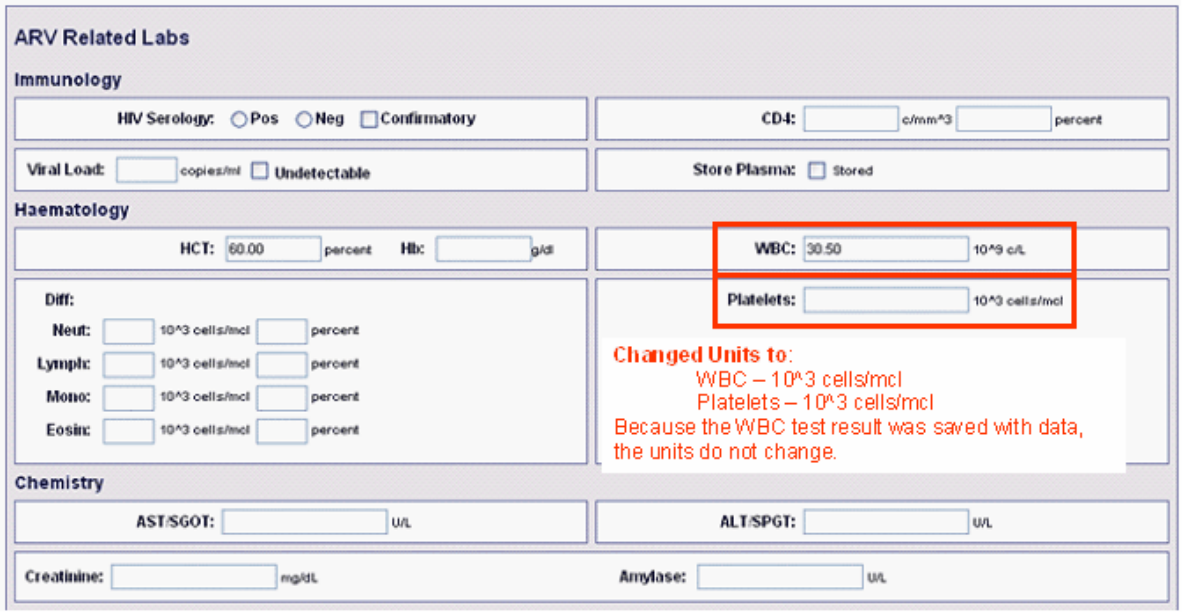
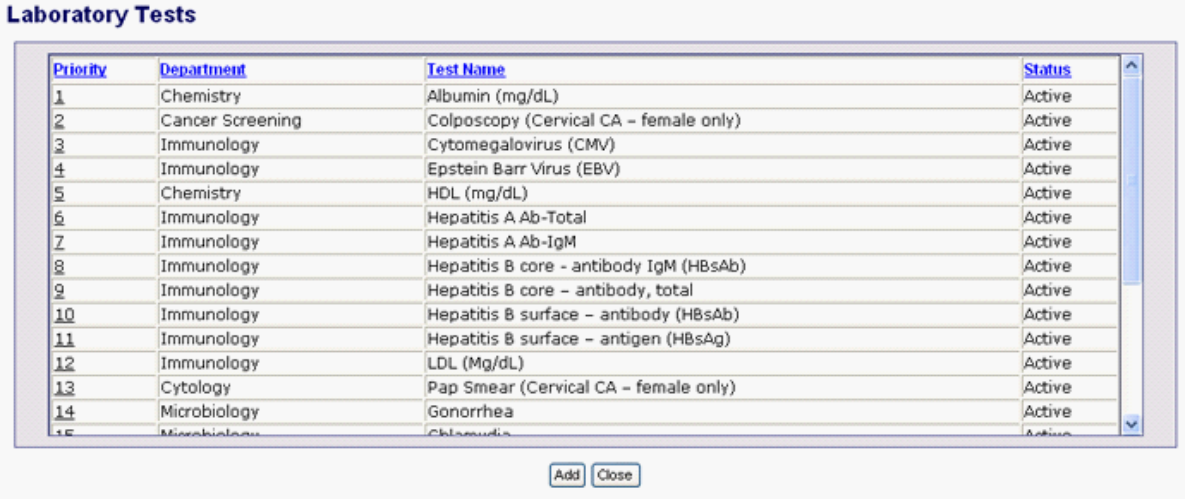


4.4.4 Configure Additional Labs

Additional Labs are lab tests that are not part of the standard Lab Order form, but are performed for a patient at your clinic. You can report on these types of lab tests by first adding them to the Additional Labs list and then selecting the lab test within in the Lab Order form. (See Laboratory Order Form for instructions on how to use the Lab Order form). Both text and numeric lab results can be configured. For lab tests with numeric lab results you must also specify the lower and upper field validation boundaries. These boundaries will be used in the Lab Order form to check for outlier results.

Add an Additional Lab

1. Select Customize Lists from the top level navigation
2. Select Additional Labs from the table of lists


Laboratory Tests
Priority Department Test Name Status
1 Chemistry Albumin (mg/dL) Active
2 Cancer Screening Colposcopy (Cervical CA – female only) Active
3 Immunology Cytomegalovirus (CMV) Active
4 Immunology Epstein Barr Virus (EBV) Active
5 Chemistry HDL (mg/dL) Active
6 Immunology Hepatitis A Ab-Total Active
7 Immunology Hepatitis A Ab-IgM Active
8 Immunology Hepatitis B core - antibody IgM (HBsAb) Active
9 Immunology Hepatitis B core – antibody, total Active
10 Immunology Hepatitis B surface – antibody (HBsAb) Active
11 Immunology Hepatitis B surface – antigen (HBsAg) Active
12 Immunology LDL (Mg/dL) Active
13 Cytology Pap Smear (Cervical CA – female only) Active
14 Microbiology Gonorrhea Active
Add
Close

3. Click Add

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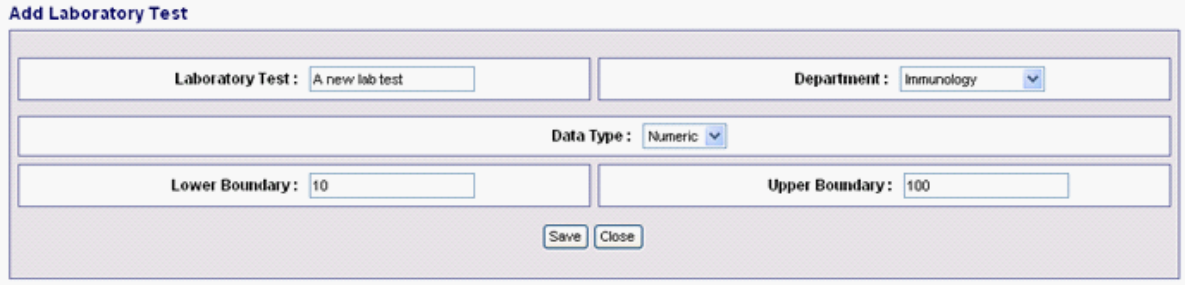
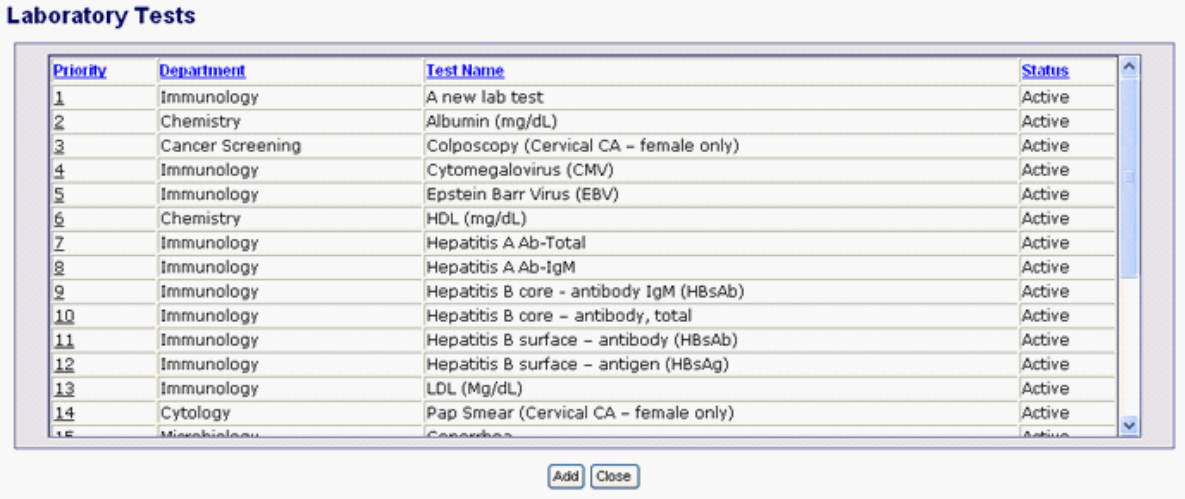
4. Enter the lab test name, the test department (test type) and the test result data type (text or numeric). If the type is numeric, enter the lower and upper boundaries.



5. Click Save


Laboratory Tests
Priority
Department
Test Name
Status
1 Immunology A new lab test Active
2 Chemistry Albumin (mg/dL) Active
3 Cancer Screening Colposcopy (Cervical CA – female only) Active
4 Immunology Cytomegalovirus (CMV) Active
5 Immunology Epstein Barr Virus (EBV) Active
6 Chemistry HDL (mg/dL) Active
7 Immunology Hepatitis A Ab-Total Active
8 Immunology Hepatitis A Ab-IgM Active
9 Immunology Hepatitis B core - antibody IgM (HBsAb) Active
10 Immunology Hepatitis B core – antibody, total Active
11 Immunology Hepatitis B surface – antibody (HBsAb) Active
12 Immunology Hepatitis B surface – antigen (HBsAg) Active
13 Immunology LDL (Mg/dL) Active
14 Cytology Pap Smear (Cervical CA – female only) Active
Add
Close

Change an Additional Lab

1. Select Customize Lists from the top level navigation
2. Select Additional Labs from the table of lists
3. Select the Additional Lab you would like to change
4. Change the lab test name, the test department (test type), or the test result data type (text or numeric). If the type is numeric, change the lower and upper boundaries. You can also make the lab test Inactive so that it will not display in the Additional Lab select list.
5. Click Update

4.5 User Group Administration

IQCare provides feature level user access for forms, reports and IQCare administration. You can specify access to particular parts of IQCare based on a User's role. For example, the person in your facility who is responsible for administering the application such as setting up the custom lists and custom fields and running donor reports would be assigned access to all features and may be part of the "IQCare Admin" group. Other Users, such as the M&E resources may only require access to view filled in forms and run reports (and not fill in forms with data) and may be part of a group with specific rights for M&E officers.

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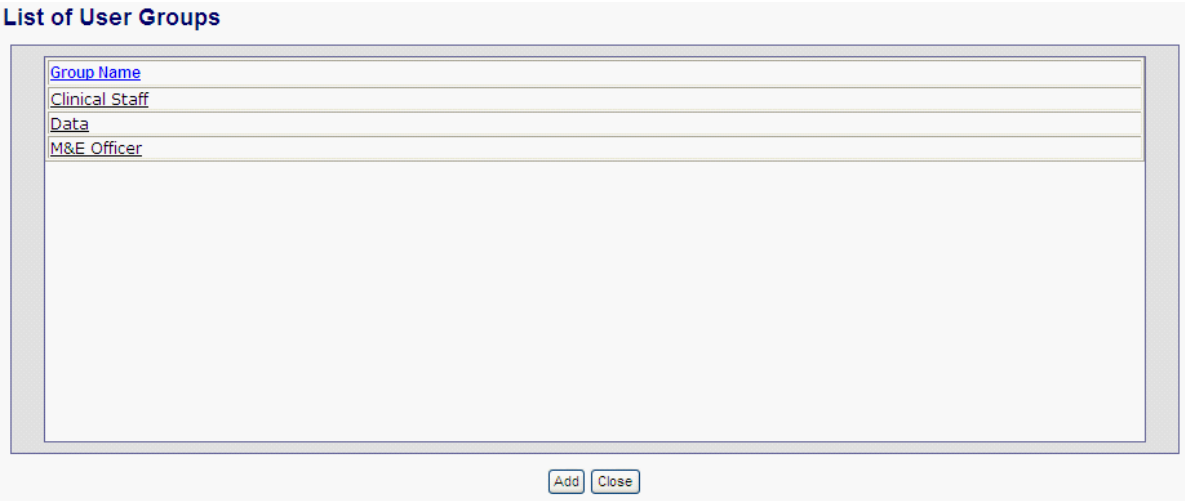
- For each clinical form, you can specify whether the user can save, update, delete and/or view the form. Be careful and make sure that the access makes sense. If you select save but not view, then the user will not be able to access the form from the navigation.
- For each report area, the access allows the user to view the report or not. As well, for all of the customizable lists and other administration areas in the application, the access allows the user to open and update the feature.
- If a User Group access rights have been changed, then all Users associated with that User Group will have their access control changed.
- The usual access configuration sequence is to first create the User Groups that have particular access and then assign one or more groups to a user. Note that if you assign more than one group to a user, the group that has the greatest access applies to the User.
- If access has not been turned on/activated for parts of the application for a User, the User will be able to view all of the pages in the application, but the Save and Update buttons are disabled.
- User Groups can not be removed from the system.

4.5.1 Add or Edit a User Group

1. From the Administration navigation, select User Group Administration
2. Select an existing User Group from User Group list or click the Add button to create a new User Group.



3. Give a new User Group name, or change the User Group name and give access rights for each area of IQCare.
4. Select or de-select the features you would like the User Group to have. Note that you must check the left-most hand check box for your selections to be saved for each row in the list. If there are no selections for a particular row, you do not need to check the left-most check box

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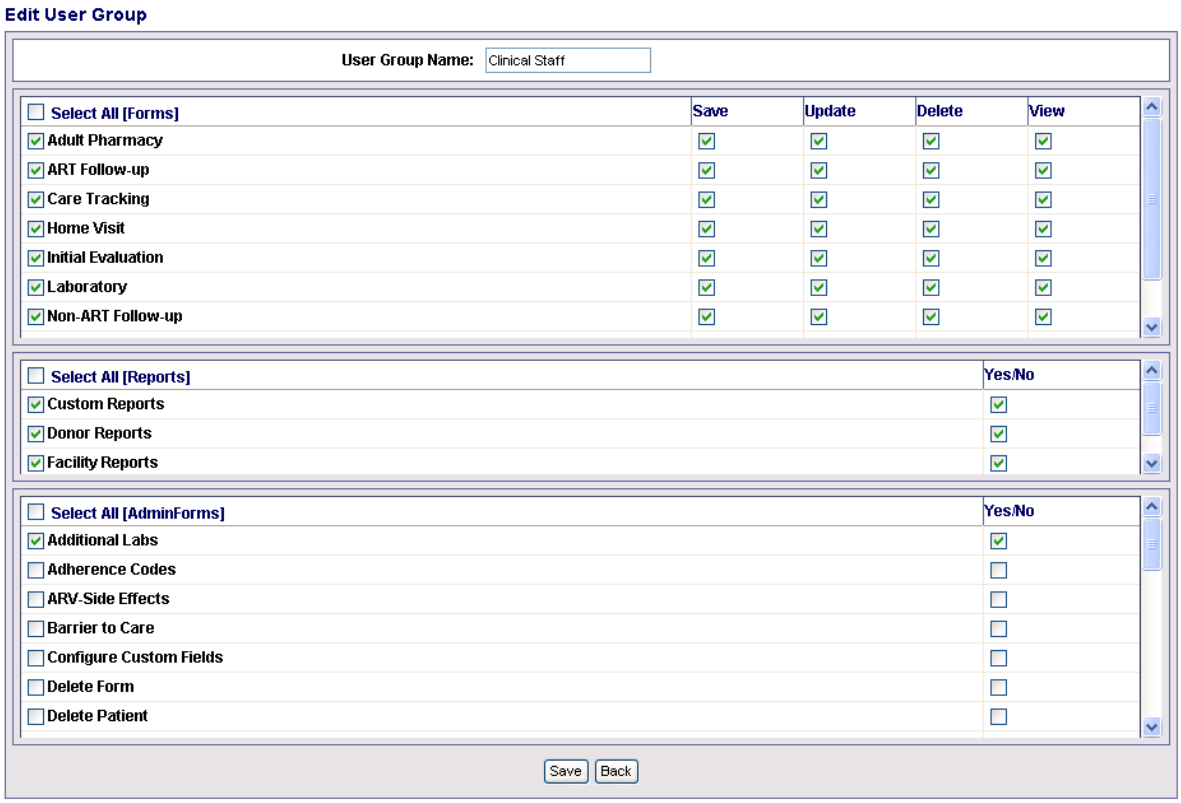

5. Click Save

4.5.2 Special Privileges Feature

There are two administrative options that have been designated as "Special Privileges". They are:

- Ability to edit the Patient Enrollment Number field
- Ability to edit the Care Tracking form

To give a user group one or both of these privileges, simply click on the check boxes next to the feature.

4.6 Employee List

Description: Specifies the employee name and designation

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Dependencies: None
Used In: All clinical forms (Signature field), Purchase order
Facts/Rules:

- Not to be confused with the store user linking; you must also link a system user (not an employee) to a store that has the privilege to purchase items in order to fill in a purchase order

Field Description

Display Label	Display Type	Field Description	Rules/Comments
First Name	Text	First name of the employee	Required field
Last Name	Text	Last name of the employee	Required field
Designation	Select list	Designation of the employee See Employee Designation custom list	Required field
Status	Select List [Active, In Active]	Hides/Displays entry	Required; defaults to active

4.7 User Administration

The User Administration feature is where you assign a User Name and Password to those individuals who will be using IQCare. Each individual should have his/her own user name and password and it should not be shared amongst employees.

A User can be active or removed from having access. Only active Users can login to the application. Once a User has been inactivated, they can not be re-activated. You would simply add that individual again, giving them a new User Name (different from the one that was originally given to them) and a Password.

4.7.1 Add or update a User

1. Click the Add button to add a new User or select an active User to edit an existing User. Note that if you select an Inactive User, the system will give you error letting you know that you can not edit an Inactive User.

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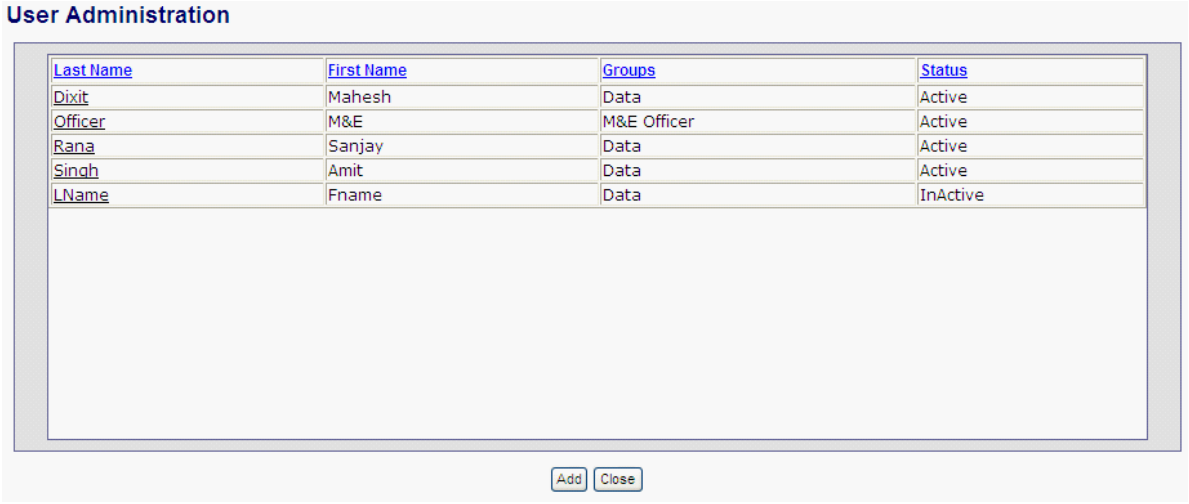

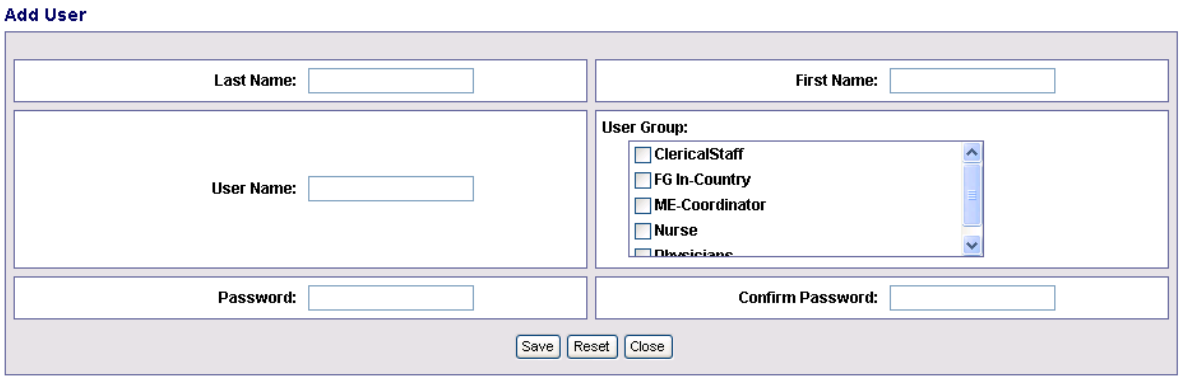

2. Enter or modify the User details. Enter the last name, first name, and username.
3. Assign the User at least one User Group. We recommend only aligning one User Group per User
4. Assign a password and retype the password to confirm spelling
5. Click Save

4.7.2 Setting the e-Signature

In the Paperless mode, a health care provide will electronically sign a clinical form by selecting his/her name at the end of the form. This limits the list of names to just the name of the person who logged in.

In this example, Susan Smith is designated with access rights of "Doctor".

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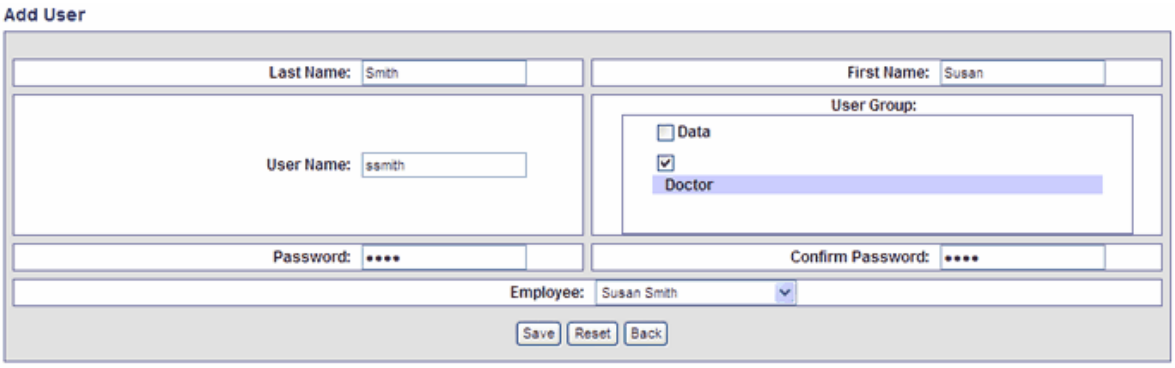
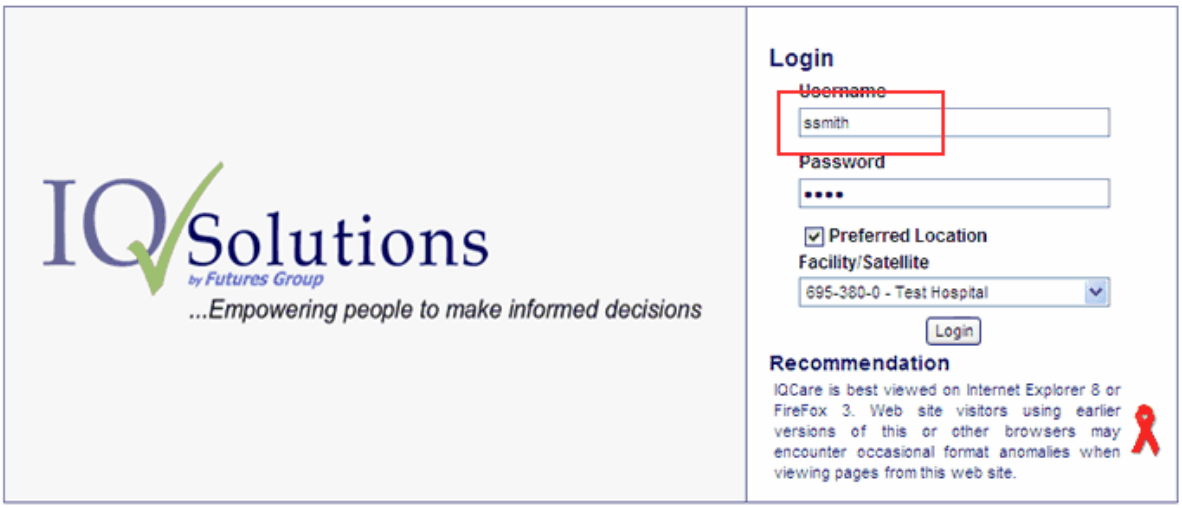
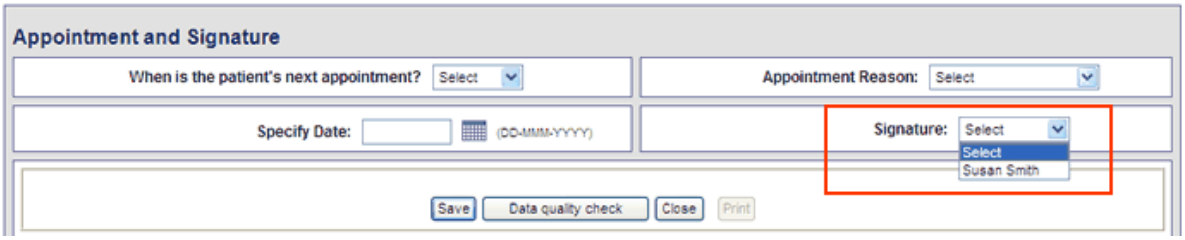


She logs in with her credentials.


IQSolutions
by Futures Group
...Empowering people to make informed decisions
Login
Username
ssmith
Password
••••
Preferred Location
Facility/Satellite
695-380-0 - Test Hospital
Login
Recommendation
IQCare is best viewed on Internet Explorer 8 or FireFox 3. Web site visitors using earlier versions of this or other browsers may encounter occasional format anomalies when viewing pages from this web site.

When she signs the clinical form, only Susan Smith's name is available for selection. This assures that only Susan Smith can sign the form.



4.7.3 Inactivate a User

1. Select the User from the User list
2. Click the Remove button.

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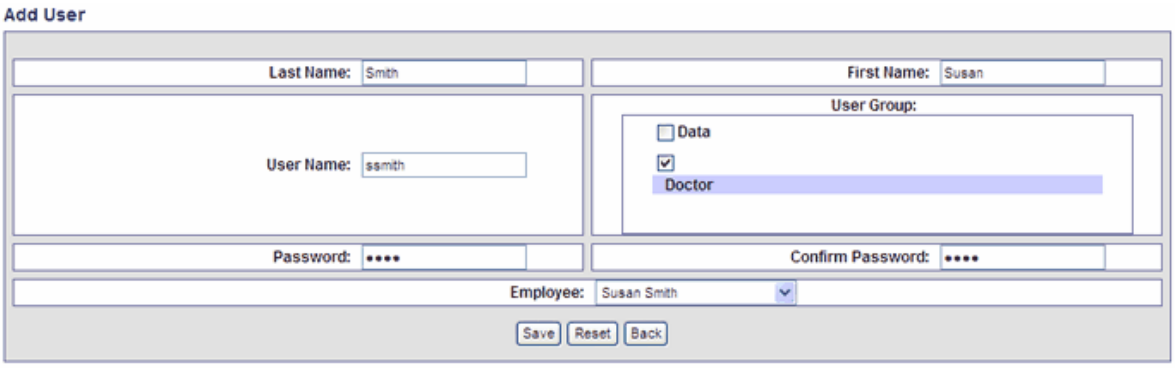
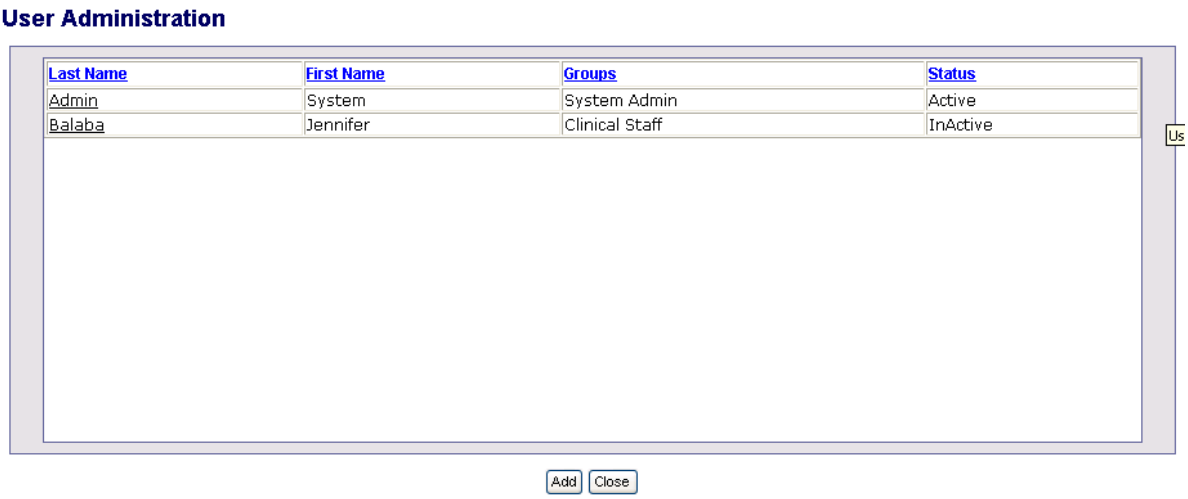


3. See that the User's status has changed to Inactive, in the User list



Note: Once the User has been inactivated, he/she can not be re-activated with the same Username. Users that have been inactivated are displayed in the User list for your convenience; if you click on the inactive User's name, you will receive an error message.

4.7.4 The System Admin User

The System Admin user type can not be removed nor can the user group associated with the System Admin user be changed. This is safeguard has been added to the system so that the administrator does not accidentally inactivate the admin account and get locked out of the IQCare system. The first and last name (admin, system) and Username (admin) and User Group (System Admin) can not be changed. The password can only be changed via the back end database.

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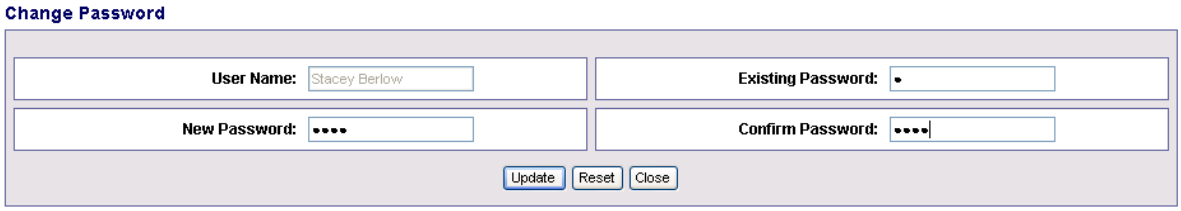
4.8 User Passwords

For IQCare, there are no special password requirements or restrictions. Special characters can be used within the password. You should have your own IQCare Username and password and should not share these access credentials with other users. Your IQCare Administrator will create a Username and Password for you. Once you have your Username and Password, you should change your password so that only you know it.

4.8.1 Change Password

1. Click the Password link found in the upper right hand corner of every IQCare page.



2. Enter the existing password
3. Enter the new password and re-type it to verify that you have not made any typing errors.
4. Click update

4.9 Delete patient

It is recommended that only the IQCare Administrator have the rights to delete a patient. Setting the rights to delete a patient is done through the User Group Administration. Once a patient is deleted, you can not retrieve it in any way and you must re-enter the patient information.

1. Select Delete Patient from the top level navigation
2. Using the search fields provided, find the patient you would like to delete. Note that clicking on the Find button without any entries in the fields will give you the entire list of patients.

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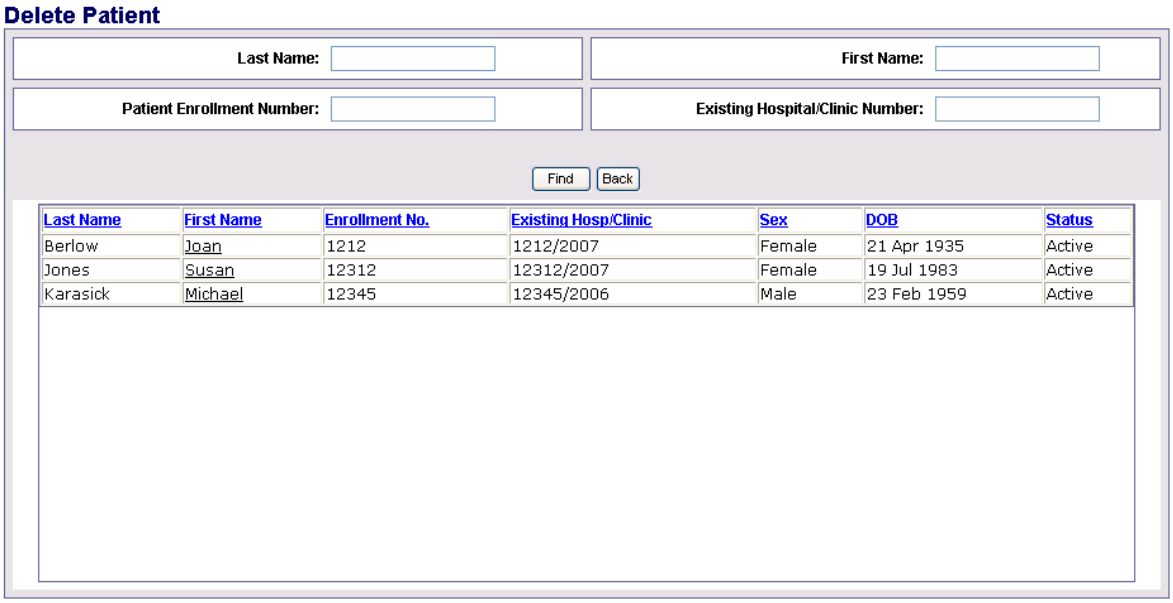
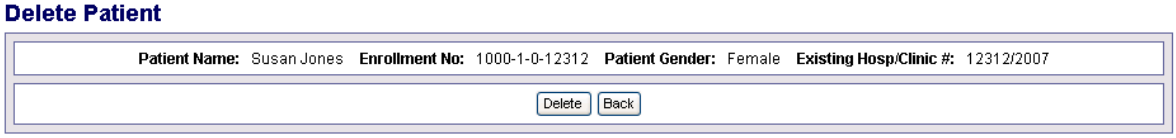


3. Select the patient by clicking on the line with the patient's name
4. Verify that the patient you are about to delete is the correct patient


Delete Patient
Patient Name: Susan Jones Enrollment No: 1000-1-0-12312 Patient Gender: Female Existing Hosp/Clinic #: 12312/2007
Delete
Back

5. Click the Delete button
6. A verification dialog box will appear asking you if you are sure you would like to delete the patient.
7. Click Yes to delete the patient.

4.10 Configure Custom Fields

Custom fields allow the Administrator to add fields to the end of each clinical form.

Custom fields are available to be added to the following forms:

HIV Care Static Forms
HIV Care Patient Enrollment
Initial Evaluation
Adult Pharmacy
Paediatric Pharmacy
Laboratory
Non-ART Follow-up
ART Follow-up

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Care Ended (add custom fields via IQCare Management)
Home Visit

The types of fields that can be added to the forms are:
- Text – single line
- Text – multi line
- Select list
- Date
- Numeric – integer or decimal
- Yes/No
- Multi-Select Check list

- You can add the same custom field to more than one form
- There is no limit to the number of custom fields you can add to each form
- Custom fields display left-right, left-right in a horizontal manner on a clinical form
- Custom fields can be re-arranged within the form
- Select and multi-select Custom Fields are created via the Custom Field link and the select box entries can be updated via the Customize Lists

4.10.1 Add a Custom Field

Custom field rules:
- Custom field labels and types must be unique.
- The combination of the field name and field type is what makes the field unique.
- It is not possible to have a field name the same field label name and two different field types
- The character limit for the field label name is 90 characters including spaces
- IQCare automatically adds a form name pre-fix such as Enroll, IEval, APharm, etc., to the field label name. For those custom fields that are on multiple forms, the pre-fix makes the form label unique so that it can be easily found in custom reports.
- The field label name must start with a non-numeric character.

To add a custom field:
1. Navigate to the Custom Fields page
2. An empty custom field form will display
3. Select the form or forms on which you would like the custom field to display
4. Type in the custom field label
5. Type in the description (optional)
6. Select the field type

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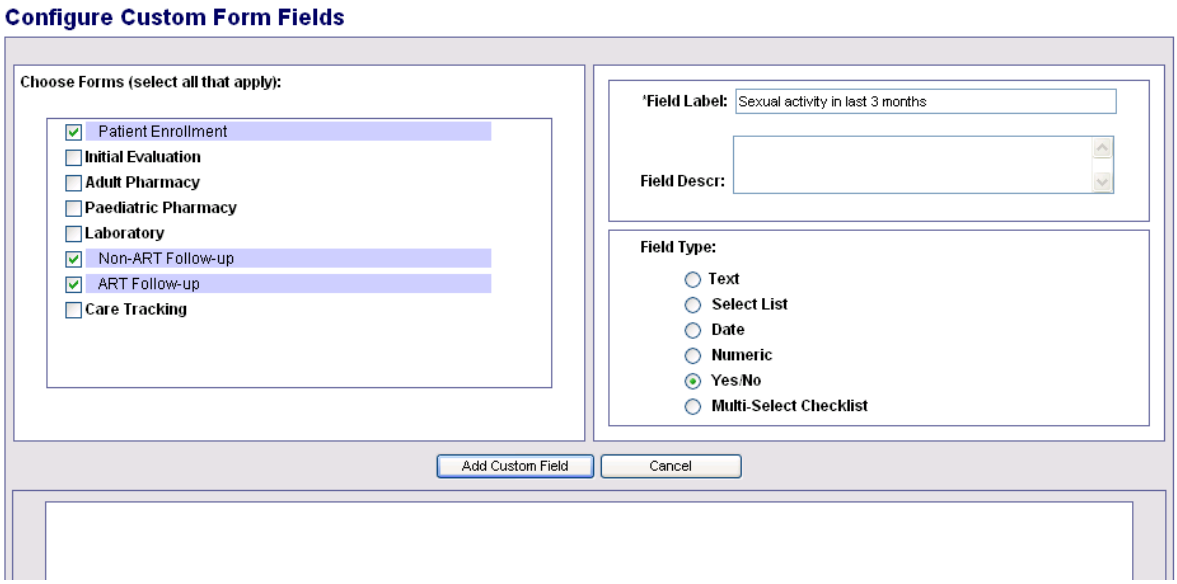
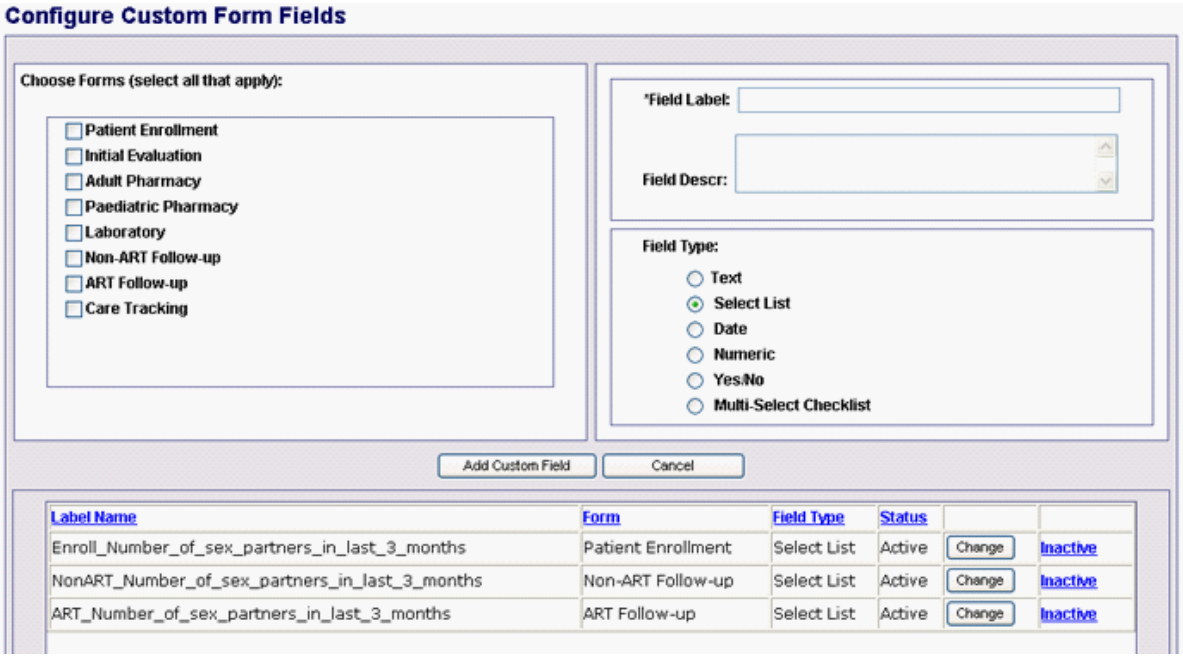


7. Click the Add Custom Field button to save your entries. Your custom field configuration will display at the bottom of the Custom Fields page.
8. Repeat for additional Custom Fields



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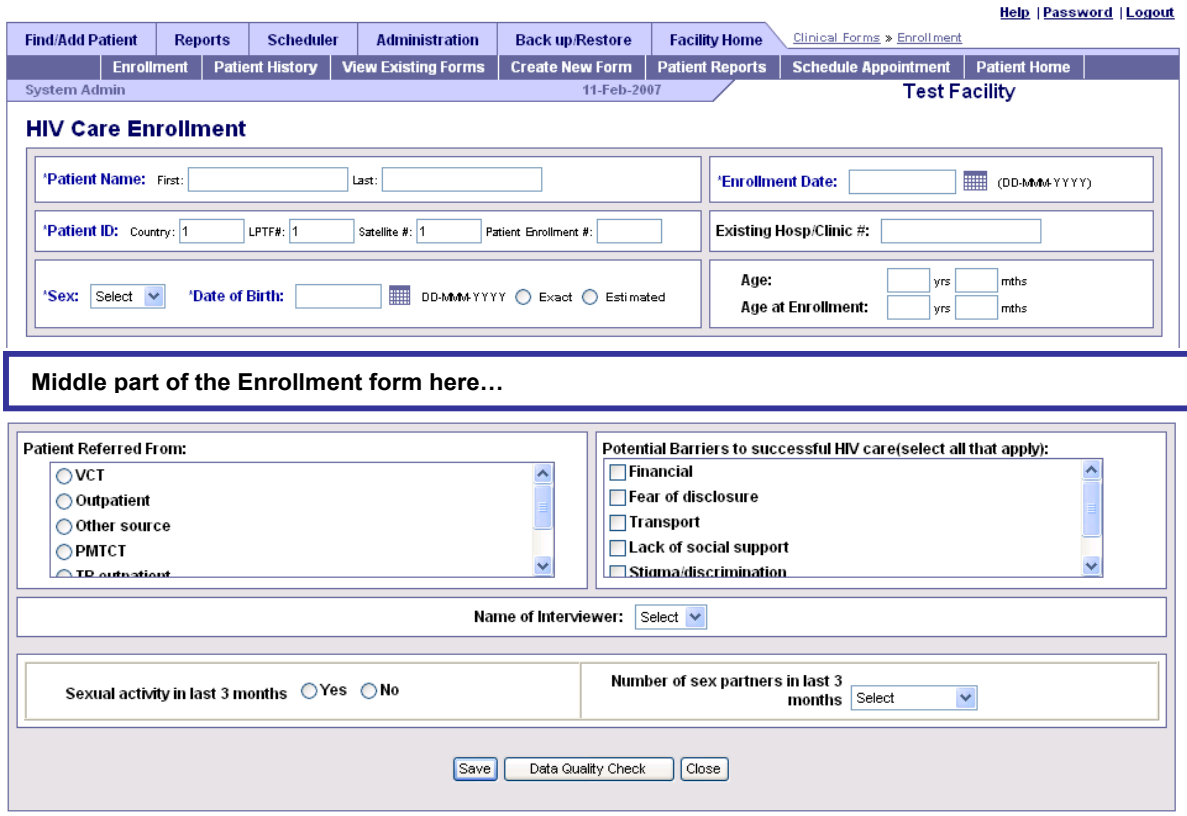

Middle part of the Enrollment form here…

4.10.2 Add Custom Field Lists

The process for adding select lists and multi-select lists is the same. IQCare allows you to specify the items in the select lists right at the time you are configuring the Custom Field. Once the field is added, the select list is also added as an unrestricted list to the Customize Lists, found under Administration in the Facility Navigation. If you want to modify the entries in an existing custom field select list, you would do that via the Custom Lists.

Adding a select list of multi-select list

1. Navigate to the Custom Fields page
2. The custom field page displays
3. Select the form or forms on which you would like the custom field to display
4. Type in the custom field label and description

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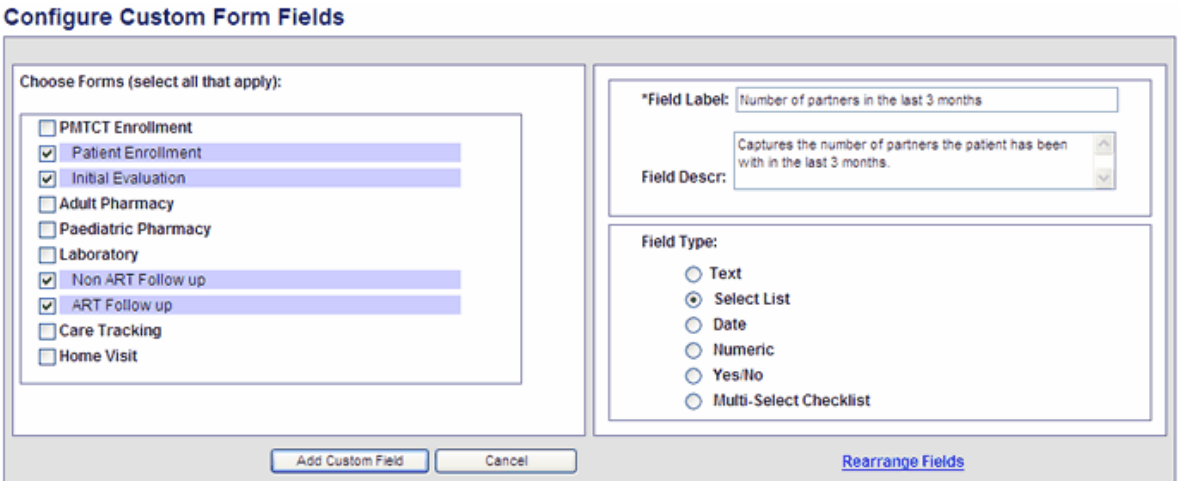

5. Select either the Select List or Multi-Select List; a new window will display that allows you to enter the items in the list

a. Within the new window, enter the value and click Add
b. Repeat until complete
c. Click the Submit button to save your entries

6. Click the Add Custom Field button to save your entries

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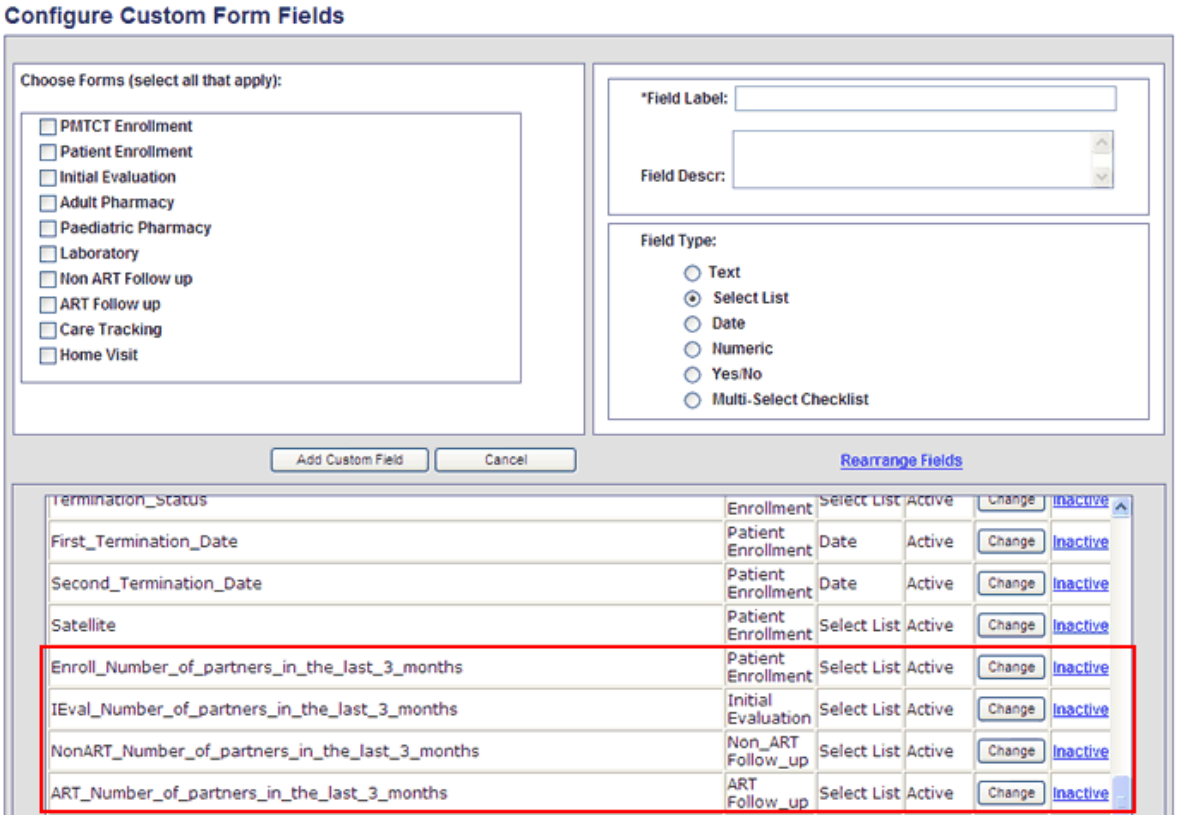

7. Repeat for additional Custom Fields

4.10.3 Change a Custom Field

IQCare has some restrictions when changing a Custom Field.

- You can not change the field type of an existing field. If you would like to change the field type, you have to add a new custom field.
- If you change the type of form, IQCare adds a custom field to the form you selected. Unselecting a form does not remove or inactivate it; to remove a custom field you must inactivate it using the Inactivate button.

To change a custom field:

1. Navigate to the Custom Fields page
2. From the list of Custom Fields provided at the bottom half of the screen, select the custom field you would like to change by clicking the Change button.
3. The configuration of the selected custom field is displayed
4. Change either the form (adds the custom field to a form), change the label or description of the custom field.
5. Click the Edit Custom Field button

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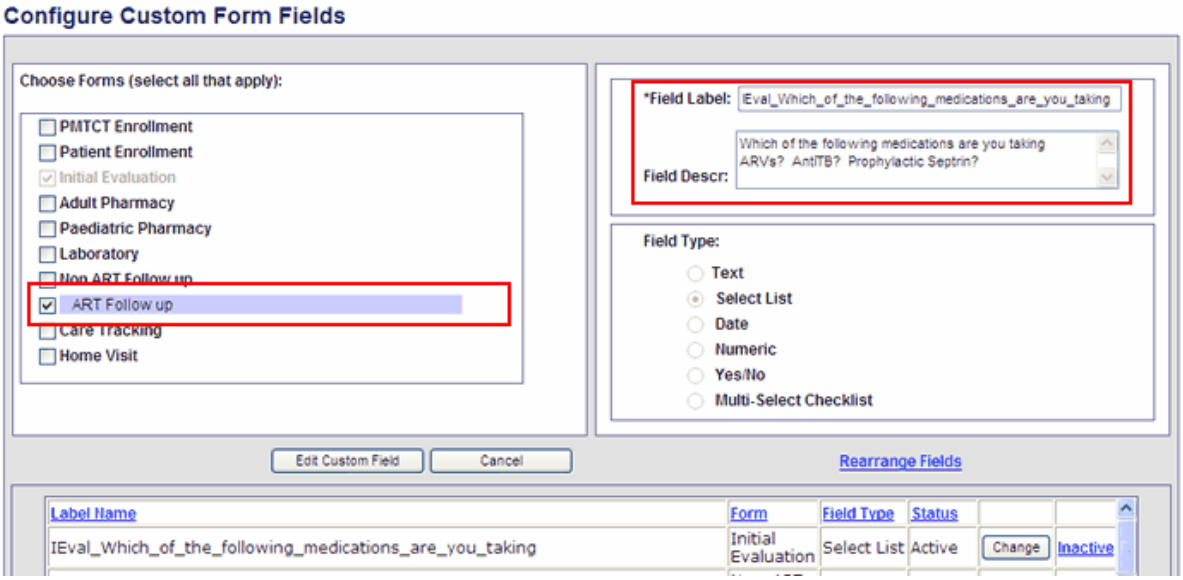
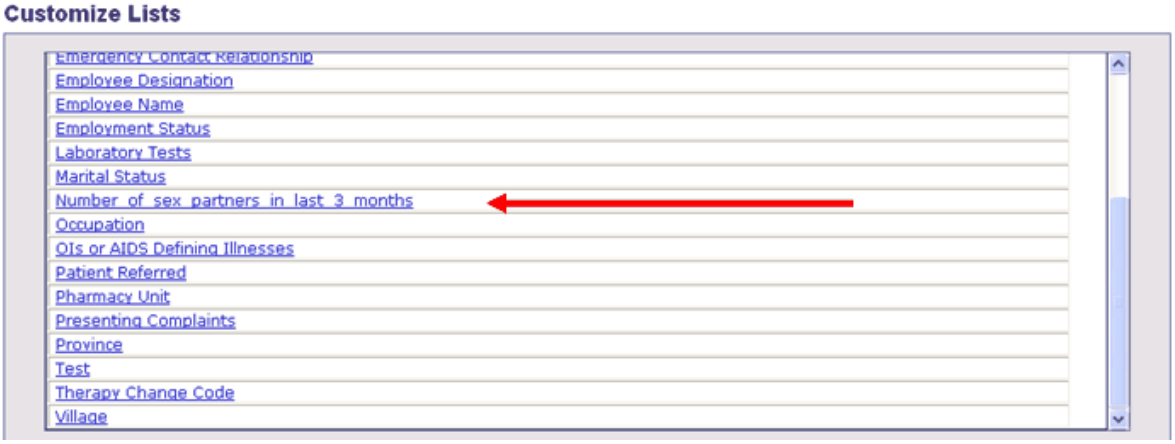


4.10.4 Change Custom Field Lists

When you create a select list or multi-select list custom field, the list is added to the set of Customize Lists. If you wish to make updated, you find the custom field list and updated from within the Customize List facility. Please see the Customize List section to find out more about how they work.

1. Navigate to Customize Lists
2. Click on the name of the custom field list you wish to update



3. Make updates to the list by adding an entry or changing the label, priority or remove it from display by inactivating the list entry.

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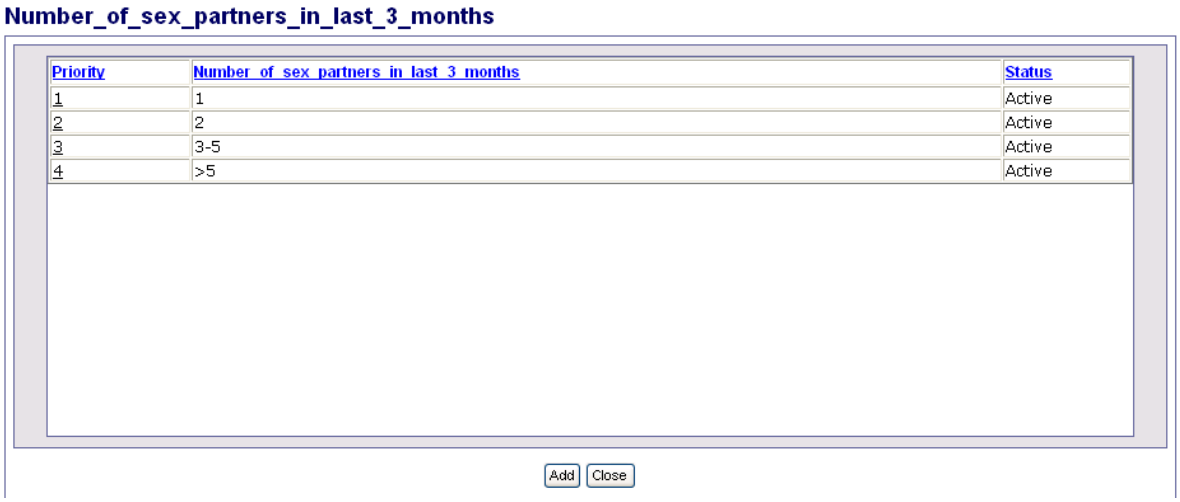
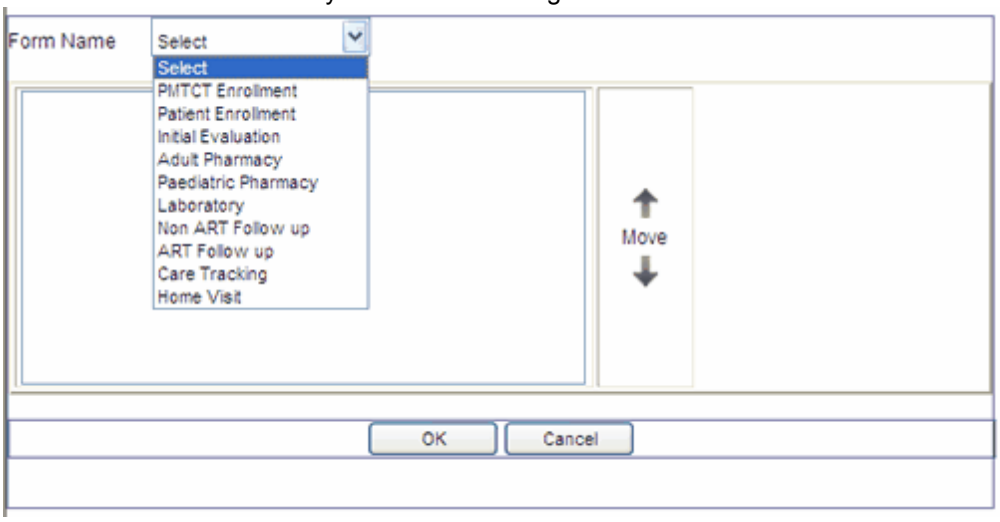


4. Click Save to save updates

4.10.5 Arrange Custom Fields in Forms

1. Navigate to the Custom Fields page
2. Click on the Rearrange Fields link; a dialog will display
3. Select the form for which you want to rearrange the custom fields



4. Highlight the custom field you would like to move and use the up and down arrows to move the field to the new location.

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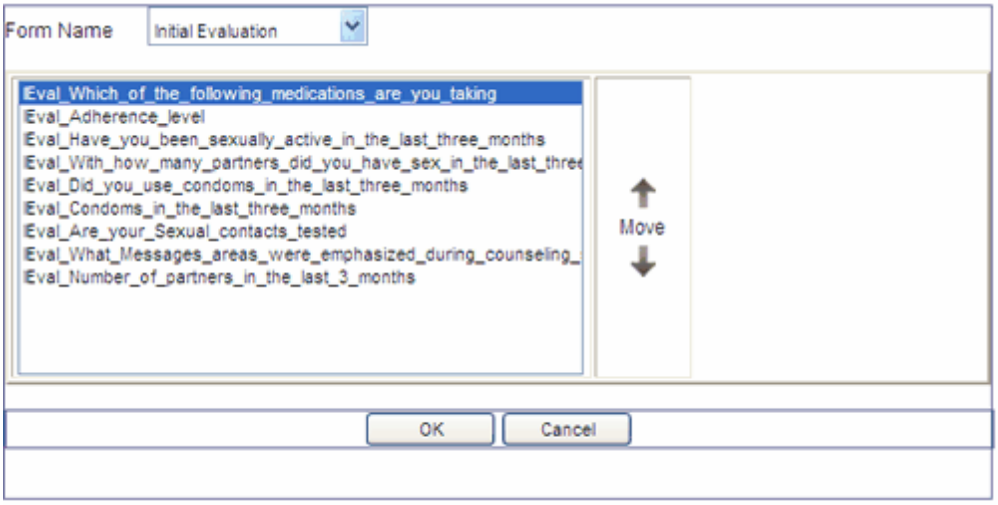

5. Click OK

4.10.6 Inactivate a Custom Field

Inactivating a custom field is as simple as clicking the Inactivate link. Once the custom field is activated, you can re-active the field by clicking the Activate link.

Inactivating a custom field:

- Changes the status of the custom field in the custom field list;
- Removes the selected forms
- Removes it from the custom lists if all the instances of the custom fields have been inactivated

- Inactivating a custom field **does not** remove the results from the database. The data continues to be stored in the database so that it can be queried through custom reports.

- When you inactivate a custom field, the existing fields on the form shift back one or more places, depending on the number of fields you have removed.

To inactivate a custom field:

1. Navigate to the Custom Fields page
2. From the list of Custom Fields provided at the bottom half of the screen, click the Inactivate button.
3. The field status changes in the bottom of the Custom Fields page

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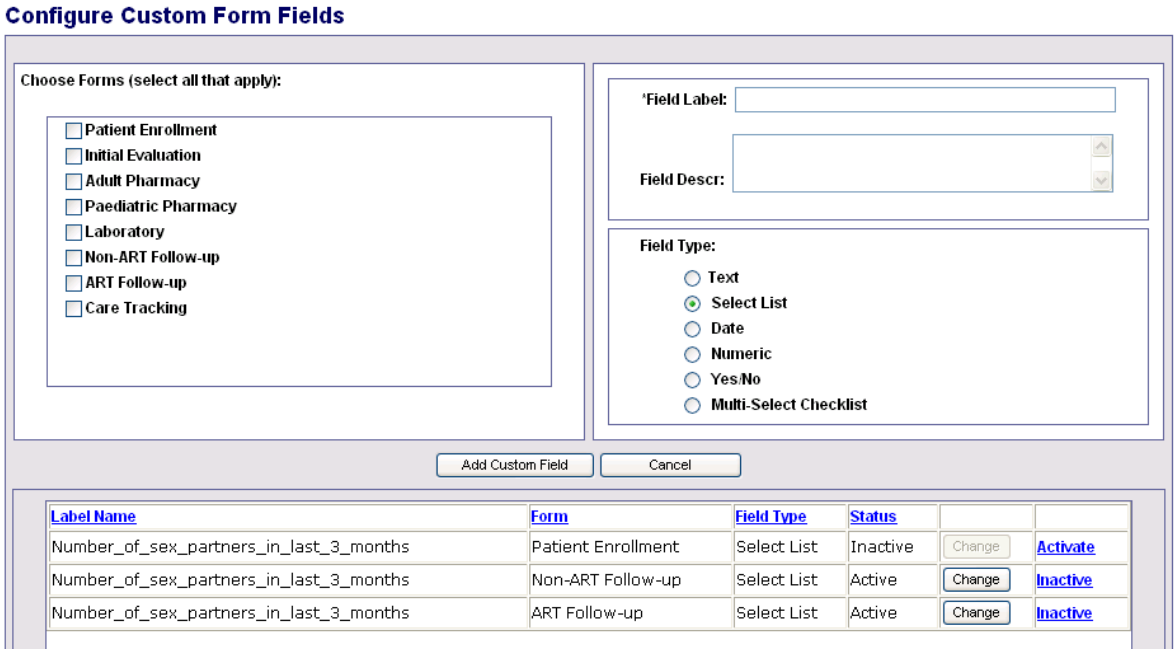

4.11 Refresh Caches

"Cache" (pronounced *Cash*, like the money) is a way of saving information on your computer for increased performance. IQCare saves two types of information

1. The master lists that are found in the Customize Lists
2. The clinical (form) data that is used to create Custom Reports

By having this information in a more accessible format, IQCare can work faster and you don't have to wait as long for the pages to refresh or repaint.

To refresh the caches, go to the Administration section and find Refresh System Cache and Refresh Reporting Tables.

4.11.1 Refresh System Cache

IQCare saves the master lists from the Custom Lists, on your local computer as XML files. These special files are very quick for the computer to read and because they reside on your local machine, IQCare does not have to go back to the server to retrieve the information each time you create a new

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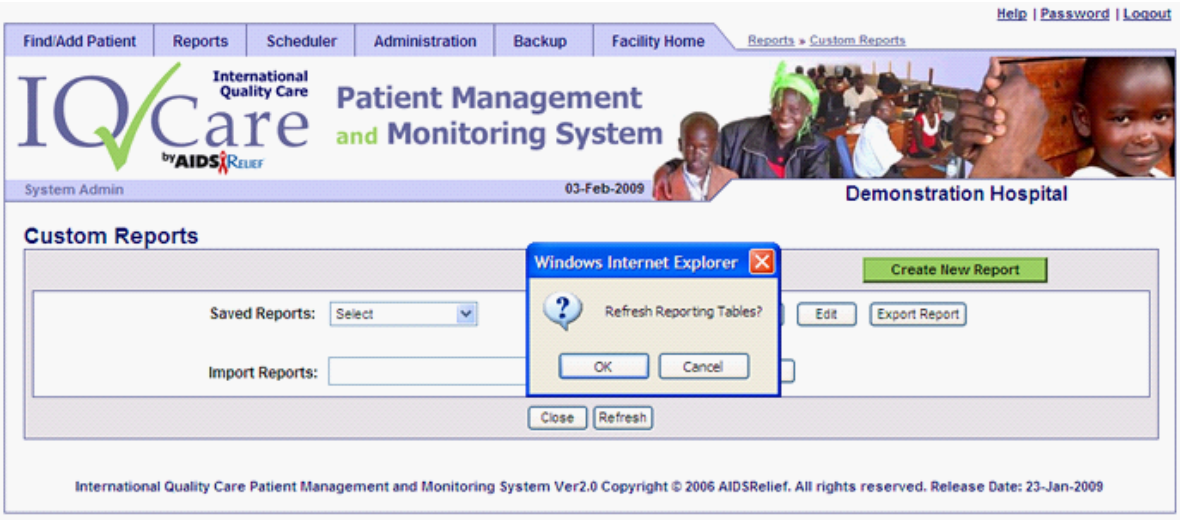
(empty) clinical form.

Because the select list data are initially saved to your local hard drive when you start the application, if you make changes to the custom lists they will need to be manually updated in order for the most recent updates to appear in the clinical forms. Click on the Refresh System Cache navigation link to update the cache. Custom select lists including the drugs list and additional labs are affected; Custom fields are not cached.

4.11.2 Refresh Reporting Tables

IQCare saves the custom report data into a set of temporary tables in the database. All of the data for reports has been formatted in these temporary tables for easy and optimal retrieval. These tables are automatically updated upon opening Custom Reports for the first time, once per day. IQCare checks the last date that the temporary tables were refreshed and updates them automatically only if the date is different from today's date. Even if you log out and log back into the application then enter Custom Reports the application will not refresh the tables if it is on the same date.

It is very important that you manually refresh the tables before you run reports if data has been entered into forms between the time you opened Custom Reports and started running reports. By manually refreshing the reporting tables you will be assured to run your reports on the entire data set.



4.12 Export

IQCare gives you several options for exporting data. One option is found under the Export feature where you can export groups of data to Excel. The other way to export data is through the Custom Report feature where once you create a report, the results can be exported to Excel.

Field Groups
All of IQCare data has been organized by like-field groupings which are used for the reporting table structure. For example all of the patient demographic data is grouped together in the Patient Demographic field group. These same field grouping are also used for Custom Reports. You can export one or more groups of fields to Excel.

When exporting field groups to Excel, there is a maximum of 256 fields that can be exported. This is

the maximum number of fields that can be placed horizontally in an Excel spreadsheet. This limitation is based on the Microsoft Web Office Objects that is used to create the spreadsheets in the browser.

De-Identifying Data
When you check the De-Identify Data check box, a specific set of fields will not be displayed should you have selected field groupings that contain data that identifies the patient. The fields are:

HIV Care Static Form Set
This is the set of data from the HIV Care Static form set that are de-identified.

Field Group	Fields
Patient Demographics	Local Council Patient Address Patient First Name Patient Last Name Patient Name Patient Phone Province Village
Patient Contacts	Emergency Contact Address Emergency Contact Name Emergency Contact Phone
Family Information	Family Member Name

4.12.1 Exporting Data

1. Navigate to the Export page

2. Select the field groups you wish to export

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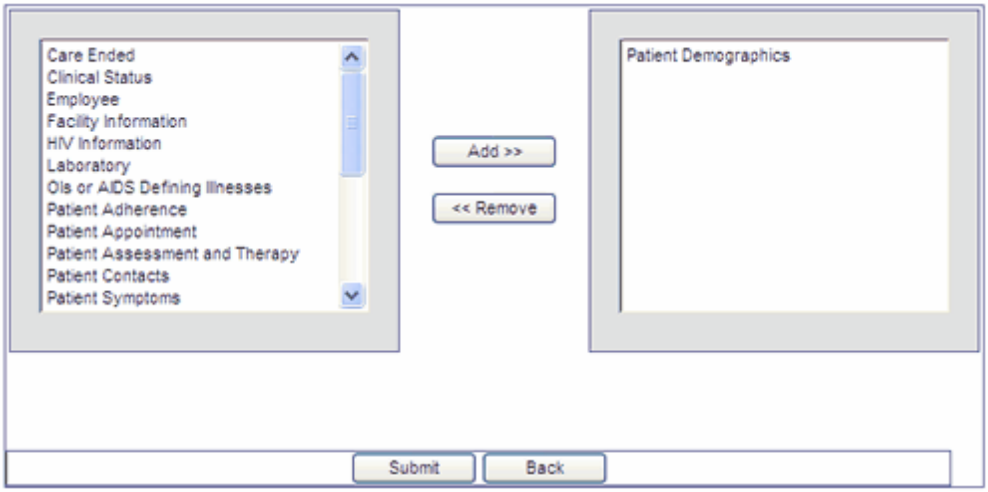
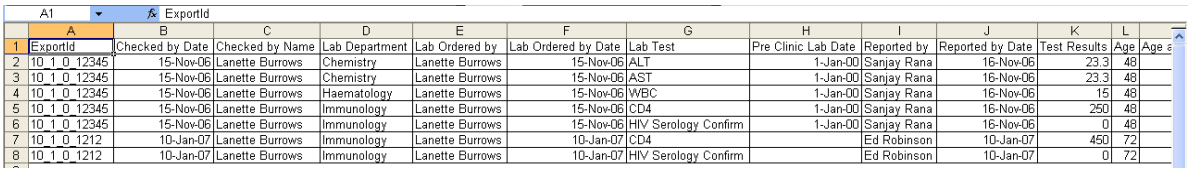


3. Select the Excel radio button
4. For De-Identified data, leave the check box checked; For identified data, uncheck the check box

5. Click the Export button
6. For the Excel output option, a dialog opens asking you if you which to Open or Save the Excel spreadsheet. If you choose Open, Excel is started and data is populated in the sheet with the default sheet name of Export.xls; if you choose the Save, a dialog opens asking you for a location on your system to save the file.



	A	B	C	D	E	F	G	H	I	J	K	L
1	ExportId	Checked by Date	Checked by Name	Lab Department	Lab Ordered by	Lab Ordered by Date	Lab Test	Pre Clinic Lab Date	Reported by	Reported by Date	Test Results	Age
2	10_1_0_12345	15-Nov-06	Lanette Burrows	Chemistry	Lanette Burrows	15-Nov-06	ALT	1-Jan-00	Sanjay Rana	16-Nov-06	23.3	48
3	10_1_0_12345	15-Nov-06	Lanette Burrows	Chemistry	Lanette Burrows	15-Nov-06	AST	1-Jan-00	Sanjay Rana	16-Nov-06	23.3	48
4	10_1_0_12345	15-Nov-06	Lanette Burrows	Haematology	Lanette Burrows	15-Nov-06	WBC	1-Jan-00	Sanjay Rana	16-Nov-06	15	48
5	10_1_0_12345	15-Nov-06	Lanette Burrows	Immunology	Lanette Burrows	15-Nov-06	CD4	1-Jan-00	Sanjay Rana	16-Nov-06	250	48
6	10_1_0_12345	15-Nov-06	Lanette Burrows	Immunology	Lanette Burrows	15-Nov-06	HIV Serology Confirm	1-Jan-00	Sanjay Rana	16-Nov-06	0	48
7	10_1_0_1212	10-Jan-07	Lanette Burrows	Immunology	Lanette Burrows	10-Jan-07	CD4		Ed Robinson	10-Jan-07	450	72
8	10_1_0_1212	10-Jan-07	Lanette Burrows	Immunology	Lanette Burrows	10-Jan-07	HIV Serology Confirm		Ed Robinson	10-Jan-07	0	72

4.13 Back up/Restore

Back up and restore FAQs

When does the back up execute?

- The IQCare database will be backed up automatically, on a daily schedule, as per the time specified

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in the Back Up Setup page.
- You can back up the IQCare database manually at any time by clicking on the BackUp button in the System Back-up/Restore page. You can run the restore function with users on the system.

Does it back up the whole database?
- Backing up the database backs up the entire database - all location data

Where does the back up file save?
- The back up file will be saved on the drive specified with in the Back up Setup page with the folder name IQCareDBBackup with the filed name “IQCare-Verx.xDD MMM YYYY.bak”. The name of the back up folder can not be changed.

Can I back up a de-identified version of the database?
- You can also make a de-identified back up where all of the patient identification data is changed to generic text. This de-indentified back up can not be accessed by the restore interface in IQCare. You can only restore this using SQL Express or another similar tool. This back up can be found in the IQCareDBBackup directory with the name “IQCare-Deidentified-Verx.xDD MMM YYYY.bak”

Can I use the .bak file with other databases?
- The.bak file generated by the SQL Server and can only be opened by an SQL Server database. Associated with each back up file is the date and time the back up was done.
- If you wish to make a copy of a database back up onto another media type, find the back up file within the IQCareDBBackup directory and copy it from that location.

If I restore a database will I lose the existing data?
- If you restore a database, once you have selected a version of the database to restore, the old database will be overwritten. You can run the restore function with users on the system.

4.13.1 Configure Backup

For successful backup, the time for the automated back up and the back up drive need to be specified. If these features are not configured, the defaults will be used. The back up time and back up drive are common to all facilities as it apply to the entire database.

Auto-Back Time:
- Is the time of day for an automatic back up will occur. Note that the machine where IQCare is installed must be on and active in order for the back up to occur. The automated backup can be disabled by not selecting a specific time and leaving the select list entry as “Select”.
- The default for the back up time is “Select” or the disabled mode.

Backup Drive:
- Is the drive where the database back up file will be saved. Note that a .bak file will be saved in the drive specified and in the directory, IQCareBackup. The backup drive must be selected in order for the back up to work successfully.
- The default is the C:\ drive.

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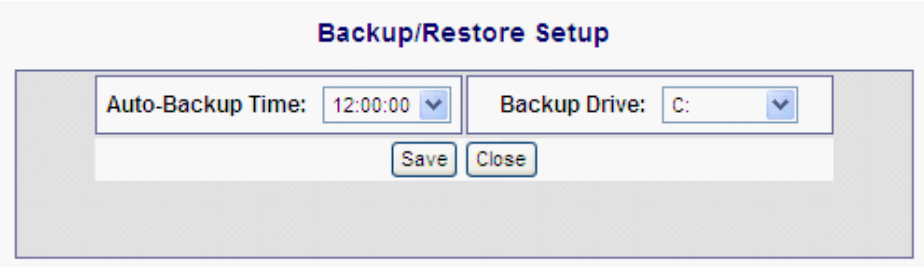
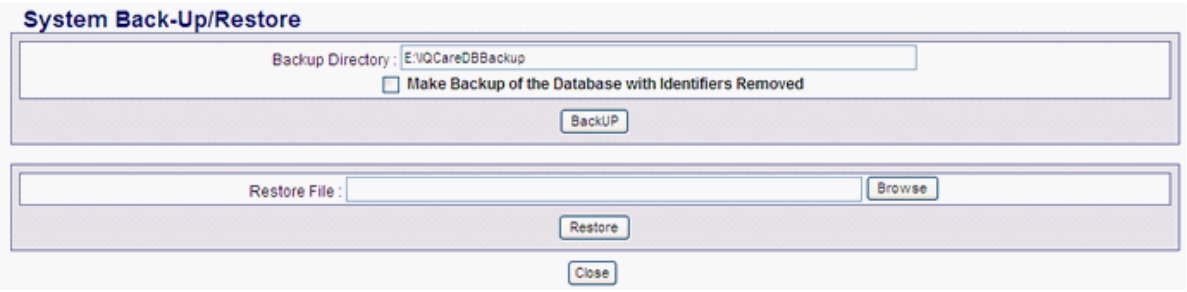


4.13.2 Make a Back up

1. Click the Back up/Restore link in the facility level navigation



2. If you want to create a de-identified back up, check the Un-identified check box. This will create a back up that is placed in the IQCareDBBackup directory and can be accessed via SQL Express. For a manual back up with identified data that can be accessed through the IQCare interface, do not check the Un-identified check box. Click the Back up button to make the back up
3. The system will indicate a successful back up

4.13.3 Restore a database

1. Click on the restore button
2. Highlight the back up file you want to restore from the list in the top part of the dialog box.

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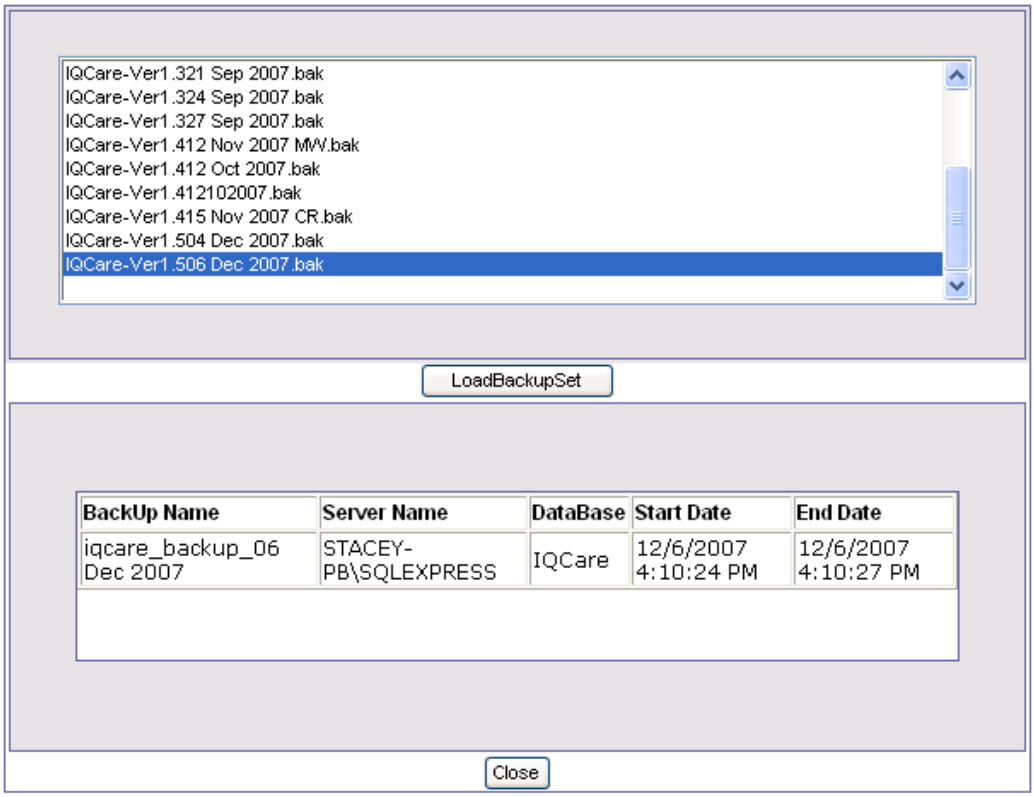
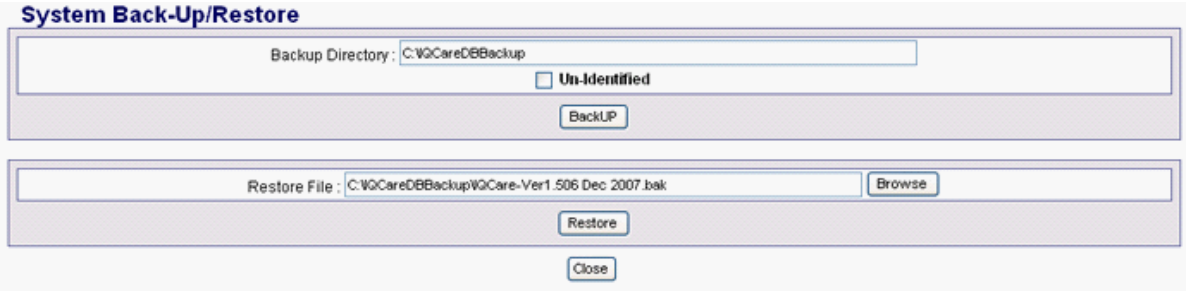


3. Click LoadBackupSet
4. Highlight the line with a previously backed up database
5. Click on the selected back up database displayed at the bottom of the dialog
6. The page focus returns to the Back Up/Restore page, with the file path of the backup file you wish to restore.



7. Click the restore button to restore the database

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Part V

5 Data Quality Assurance

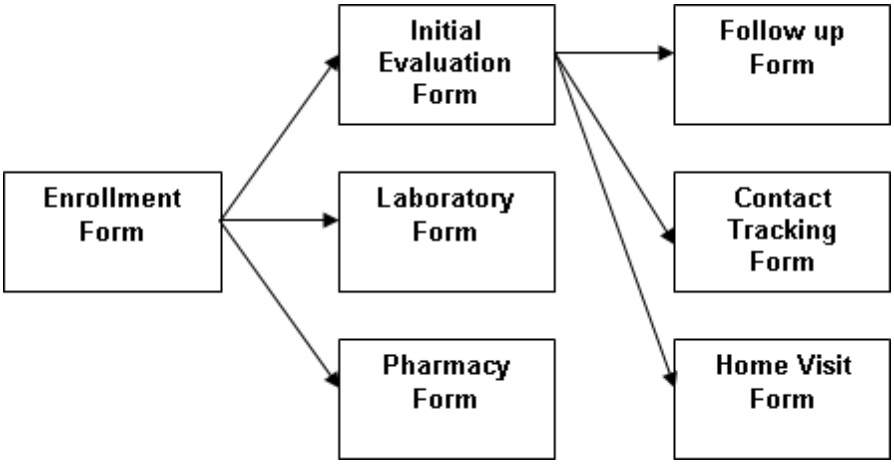
IQCare strives to help the service providers and data entry resources to enter data in an accurate and consistent way. The static HIV Care forms have been designed to have cross checks between forms for key data indicators and to prevent Users from making typographical errors. See the topics in this section for details about the data quality features provided and forms

Form Flow
Duplicate Patient Check
Required Fields
Data Quality Check
Field Level Validation

5.1 Form Flow

While there is no formal work flow (no required step-by-step process) within the application, there are several business rules that affect the sequence of forms being filled out.

- A saved version of the Enrollment form (establishing a patient record) is required before an Initial Evaluation form, Laboratory form or Pharmacy form can be filled out.
- A saved version of the Initial Evaluation form is required before a Follow up form, Contact Tracking form or a Home Visit form can be filled out.



Business rules may be associated with some of the fields on each form. These business rules include: required fields for saving, reporting and clinical use; when and how fields should be displayed or calculated; if a field is auto populated from another form. These business rules for each form can be found in Appendix E.

5.2 Duplicate Patient Check

When an Enrollment form is filled in, upon entering the patient name, IQCare checks to see if there are other patients with similar names and displays a list of those patients and key identifying information. The User closes the dialog box to either continue filling in the Enrollment form or to close the Enrollment form and find the patient already in the system.

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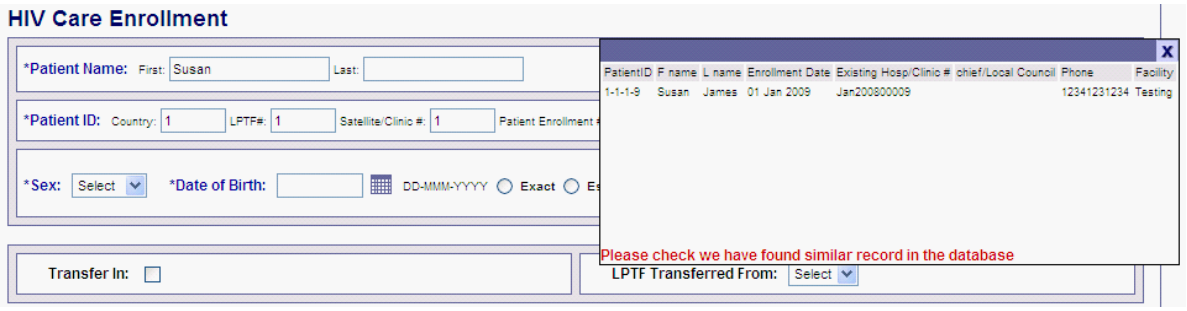
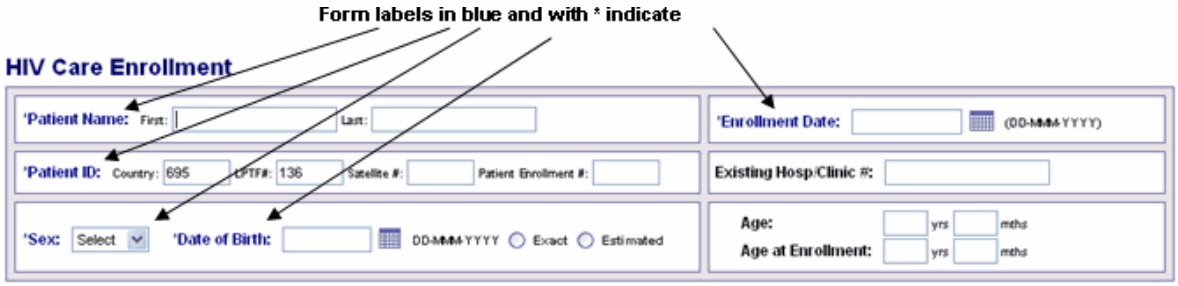

HIV Care Enrollment
*Patient Name: First: Susan Last:
*Patient ID: Country: 1 LPTF#: 1 Satellite/Clinic #: 1 Patient Enrollment
*Sex: Select *Date of Birth: DD-MMM-YYYY Exact
PatientID F name L name Enrollment Date Existing Hosp/Clinic # chief/Local Council Phone Facility
1-1-1-9 Susan James 01 Jan 2009 Jan200800009 12341231234 Testing
Please check we have found similar record in the database
Transfer In:
LPTF Transferred From: Select

5.3 Required Fields

Required fields are fields that must be filled-in in order to save a form. For example, the visit date in the Initial Evaluation and Follow-up forms or the Dispensed by and Dispensed by date in the Pharmacy forms.

Required fields are indicated on each clinic form with a blue label and star. As well, if you attempt to save a form without filling out all of the required fields, the system will alert you to do so in order to save. Once you have saved a form, you can always go back into the form to update the required fields or add/update non-required fields.


Form labels in blue and with * indicate
HIV Care Enrollment
*Patient Name: First: Last:
*Enrollment Date: (DD-MMM-YYYY)
*Patient ID: Country: 695 LPTF#: 136 Satellite #: Patient Enrollment #:
Existing Hosp/Clinic #:
*Sex: Select *Date of Birth: DD-MMM-YYYY Exact Estimated
Age: yrs mths
Age at Enrollment: yrs mths

5.4 Data Quality Check

The set of fields for the data quality check are those that are required for the Track 1.0 report and also those that IHV has determined to be the absolute minimum information for best practices in treating AIDS patients. It is not required that these fields are filled in.

HIV Care Static Form Set

The forms that do have a Data Quality Check are:

- Enrollment
- Initial Evaluation
- ART Follow-up
- Non-ART Follow-up
- Care Ended
- Home visit

The forms that do not have a Data Quality Check are:

- Adult Pharmacy
- Paediatric Pharmacy
- Lab Order

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The reason the pharmacy and lab forms do not have a data quality check is that the check is integrated into the form itself. There is no specific Track 1.0 or clinical best practices fields that need to be filled out. The laboratory form has data level validation built in.

Forms Built Using Form Builder

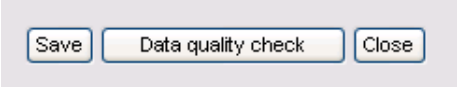
Forms that use fields that have a data quality check business rule turned on will have the Data Quality Check button displayed in IQCare. If no data quality check business rule is turned on for any fields within a form, the data quality check button will not display.

Using the Data Quality Check Feature

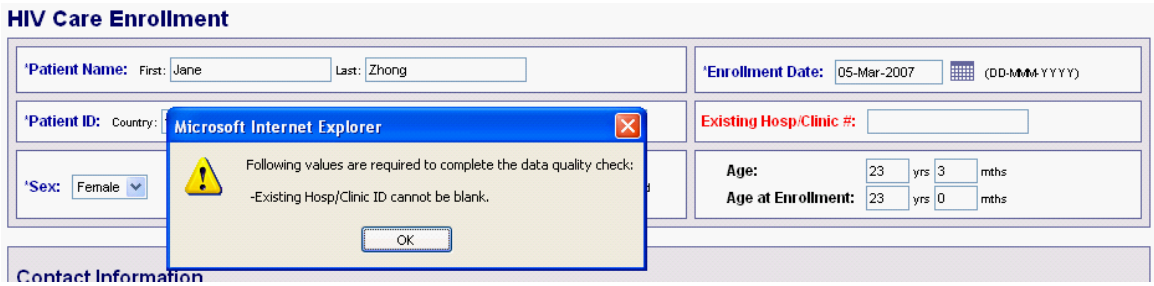
The Data Quality Check is not automatically executed by IQCare, you must click the Data Quality Check button found at the bottom of a clinic form. If all of the Data Quality Check fields are filled in, then the form is given a status of Data Quality Checked. This status flag can be used via Custom Reports to determine which forms may need some additional attention before running Donor reports.

Performing a Data Quality Check

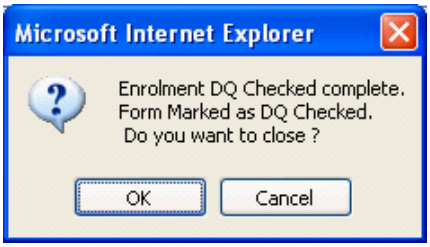
1. Click on the Data quality check button at the bottom of the form



2. If IQCare detects that certain fields have not been filled in, IQCare will alert you to which fields needs addressing by enumerating them in a dialog and highlighting the field labels in red.



3. Once you have filled in the fields, click on the Data quality check button again
4. If all of the fields are OK, then a dialog indicating that the data quality check is complete



5. The updated status is indicated with a check mark beside the form name in the View Existing Forms page. As well, if you open the form itself, the color of the data quality check button is changed to green.

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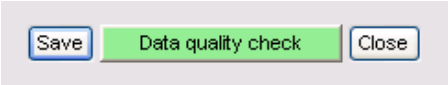

6. Any saved changes to a form changes the status of the form back to unchecked, so that you must click the Data quality check button again for IQCare to re-do that the data quality check

5.5 Field Level Validation

IQCare forms have integrated field level validation which ensures that the data entered is clean. The system has several ways to check data integrity and correctness.

- For **numeric type fields**, minimum and maximum boundary ranges are set which do not allow you to enter data outside those ranges. Example: boundaries are specified for all lab order fields
- For **date type fields**, business rules are run at the time of saving that verifies the date entered is within a reasonable date range. Example: visit date can not be greater than today's date
- For **multi-select questions**, required for best practices (Data Quality Check fields) IQCare has a "Not Documented" option for fields that have not been filled out by the clinician so that there is always an answer to each question. Example: ARV Exposure – options include: Not documented, None, list of current and past regimen questions.
- For **data flow and data integrity**, business rules are applied. Example: Pregnant and LMP questions are hidden for male patients.

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Part VI

6 Patient Level Features

Patient level features include all form data entry, the Patient Home Page and patient level reports. All individual patient information is found at the patient level.

Patient Home Page
Registration Form
HIV Care Enrollment
Patient Transfer
Create New Form
View Existing Forms
Patient Reports

6.1 Patient Home Page

The Patient Home Page displays a summary of the patient's status organized by technical area.

Facts:

- The Patient Home Page display is driven by:
  - The technical area you selected in the Select Technical Area page - only the technical area that you selected will display it its own tab.
- The General tab that displays socio demographic information and lab data is always active
- Patient identifiers for each technical area are found within the tab display
- To configure queries for a technical area tab, see Manage Home pages.
- Under Create Forms in the patient home navigation, the clinical/client forms available for data capture are those for the active technical area selected
- The Change Technical Area link goes to the Select Technical Area page so you can change the technical area of the selected patient.
- Add Children button only displays if the patient is enrolled in PMTCT
- Two charts show CD4 & Viral Load and Weight & BMI always display in the patient home page.

See Patient Home Page Business Rules for more details on the data sources and calculations.

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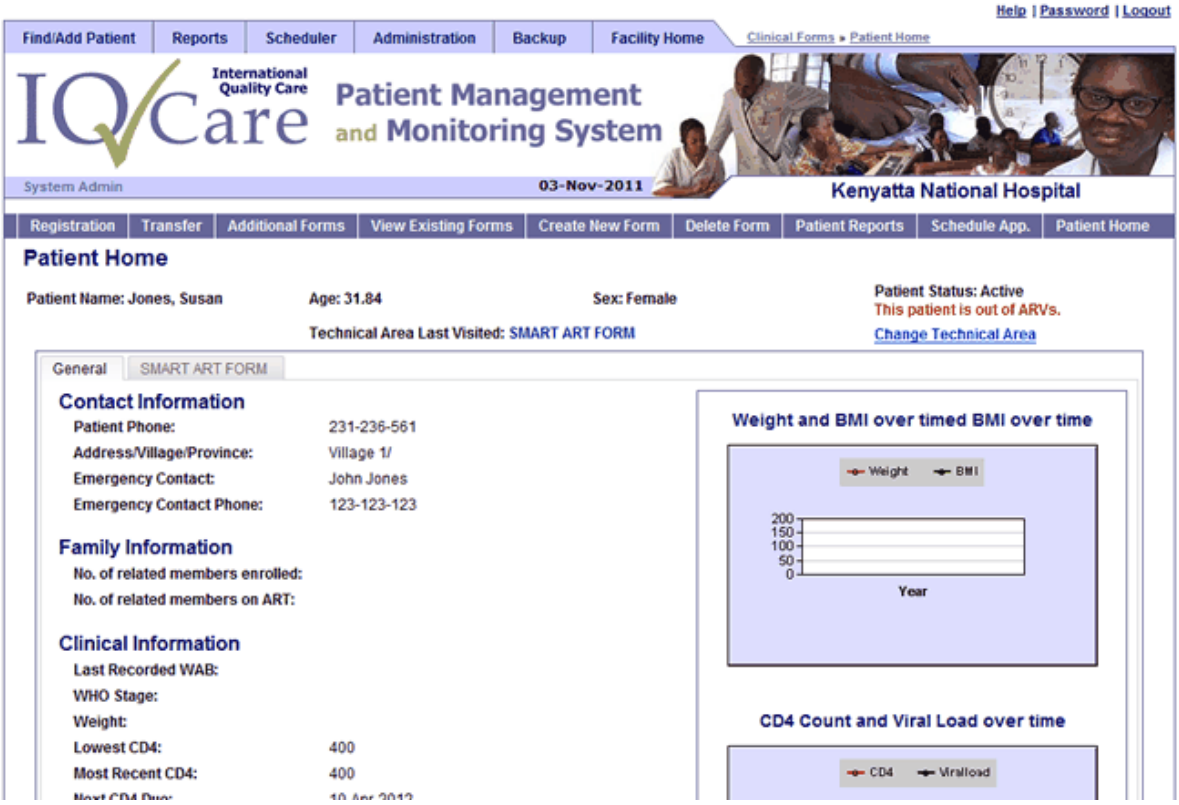

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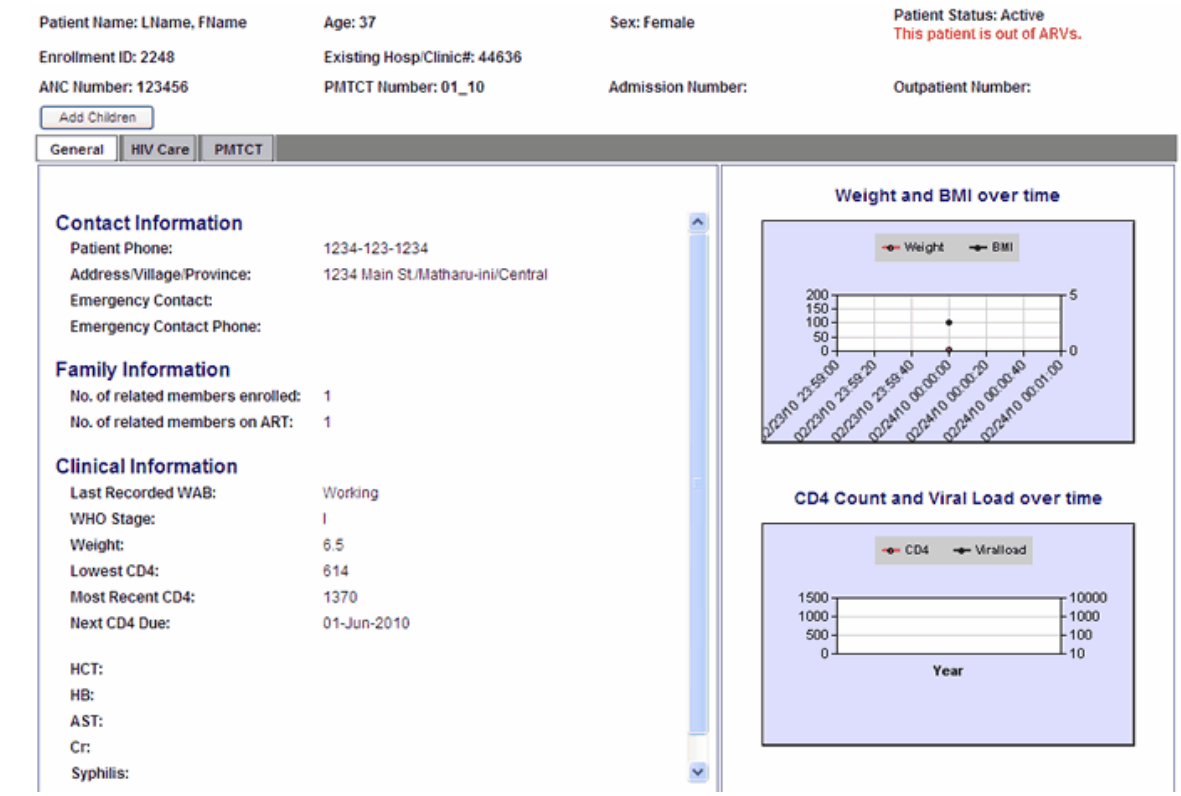
6.1.1 Patient Home Page Business Rules

General Tab



Label	Business Rule
Patient Name:	Display as Last Name, First Name
Age:	Today's date minus DOB
Sex:	Sex from ART or PMTCT enrollment form
Patient Enrollment #:	From enrollment form
Existing Hosp/Clinic #:	From enrollment form
ANC Number	From PMTCT enrollment form
PMTCT Number	From PMTCT enrollment form
Admissions Number	From PMTCT enrollment form
Outpatient Number	From PMTCT enrollment form
Add Children	This button should only display if the PMTCT option is turned on. It allows the user to register the child in the system using the mother's contact information.
Patient Home Page Graphs	
Weight and BMI	Plot all of the weight data from any form – ART or any PMTCT form

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Label	Business Rule
	Calculate the BMI and plot
CD4 and Viral Load	Plot all of the CD4 or Viral Load data from any lab form
GENERAL TAB	
Contact Information	
Patient phone:	Patient phone from ART or PMTCT enrollment form
Address/Village/Province:	HIV Care Static set: From the enrollment form – Address/PO Box, village, province
Emergency Contact:	HIV Care Static set: From the enrollment form – emergency contact name
Emergency Contact Phone:	HIV Care Static set: From the enrollment form – emergency contact phone number
Family Information	
No. related members enrolled:	From the Family Information form -- Count the number of related members enrolled in the program (where registered = yes)
No. related members on ART:	From the Family Information form -- Count the number of related members on ART (where HIV Care Status = On ART)
Clinical Information	
Last Recorded WAB	Display the last recorded WAB from the IE or Follow up forms.
WHO Stage	If not on Treatment – display the highest stage from either ART or PMTCT If on treatment – display the most recent stage from ART
Weight	Take the most recent from any form – ART or any PMTCT form.
Lowest CD4	Whichever is lowest from IE (lowest CD4) or ever measured for a patient from the Lab form
Most Recent CD4	The most recent CD4 taken from the Lab form or from the IE form (most recent CD4)
Next CD4 Due:	Last date a CD4 test was done (Reported By Date on the Lab form) + 6 months
Hb, Hct, AST, Cr, Syphilis, Pregnant	Should display the most recent lab result and date for each lab in parenthesis Syphilis Use VDRL/RPR test result from the lab form Pregnant

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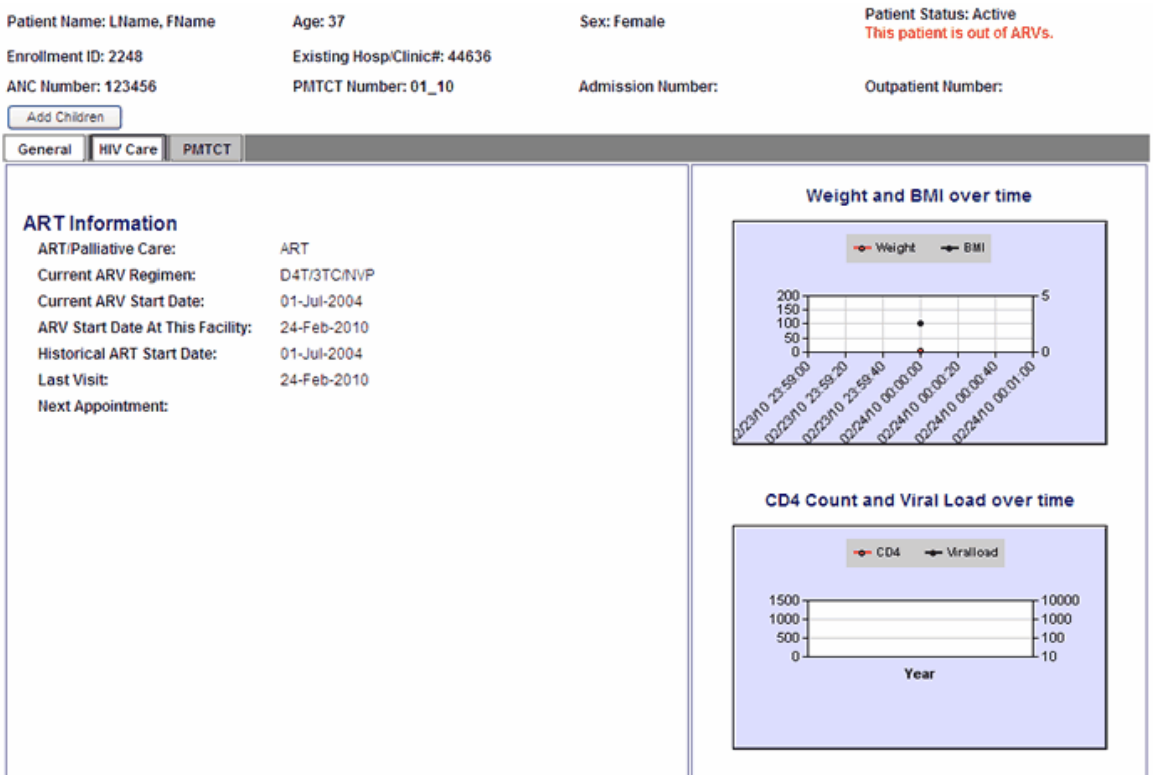
Label	Business Rule
	If a pregnancy test is positive, then display the “Positive (Reported by Date) Display if Delivery Date IS NULL OR if Reported by Date + 9 months < Today’s date

HIV Care Tab



HIV Care TAB	

ART/Palliative Care:
Options are Non-ART, ART, Due for Termination, Stopped, Care Ended)

Status	Business Rule
Non-ART	If the patient has never had a pharmacy form with ARVs dispensed AND the Treatment Program = ART AND Patient is not care ended (If the patient has had a pharmacy form with ARVs dispensed then the Treatment program can not be ART. The Treatment Program could be PMTCT, PEP, Palliative)
ART	If the patient’s last pharmacy form with ARVs dispensed + longest duration + 90 days < =today’s date And Treatment program = ART And the patient does not have a Care Tracking form with ART Ended = Yes

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Due for Termination	If the patient's last pharmacy form with ARVs dispensed + longest duration + 90 days > today's date And Treatment program = ART And the patient does not have a Care Tracking form with ART Ended = Yes
Stopped ART	If the patient has a Care Tracking form with ART Ended but still in care = Yes
Care Ended	If the patient is Care Ended, not only does his patient status Care End, his ART/Palliative status Care Ends

Current ARV Regimen:	· The regimen of upon transferring in, new or changed
Current ARV Start Date:	• Pharmacy Dispensed By Date of the ARVs dispensed of a transferred in regimen (if does not change in first pharmacy form), new or changed.
ARV Start Date At This Facility	• Pharmacy Dispensed By Date of the first ARVs dispensed in IQCare • HIV Care Static set field previously called AIDSRelief ART Start Date
Historical ART Start Date	• Date started current regimen before entering the facility (this date would be earlier than the IE visit date) • This date could be far in the past, even before the AIDSRelief program started. • HIV Care Form set: Prior Exposure section in the IE form. If a patient has this field filled-in in the IE form and yet no pharmacy form filled in with ART, the patient is considered Due for Termination.
Last Visit:	The "visit" date of the most recent form – enrollment, IE, FU, Lab, or Pharmacy (visit date, reported by date, or dispensed by date)
Next Appointment	Next appointment from the scheduler or scheduled in on of the following forms: HIV Care Form set: IE, non-ART Follow up, ART Follow up
# of related members enrolled	The number of relatives based on the family information table that are enrolled as patients at the clinic
# related members on ART	The number of relatives based on the family information table that are on ART (both enrolled as patients and non-patients)

PMTCT Tab

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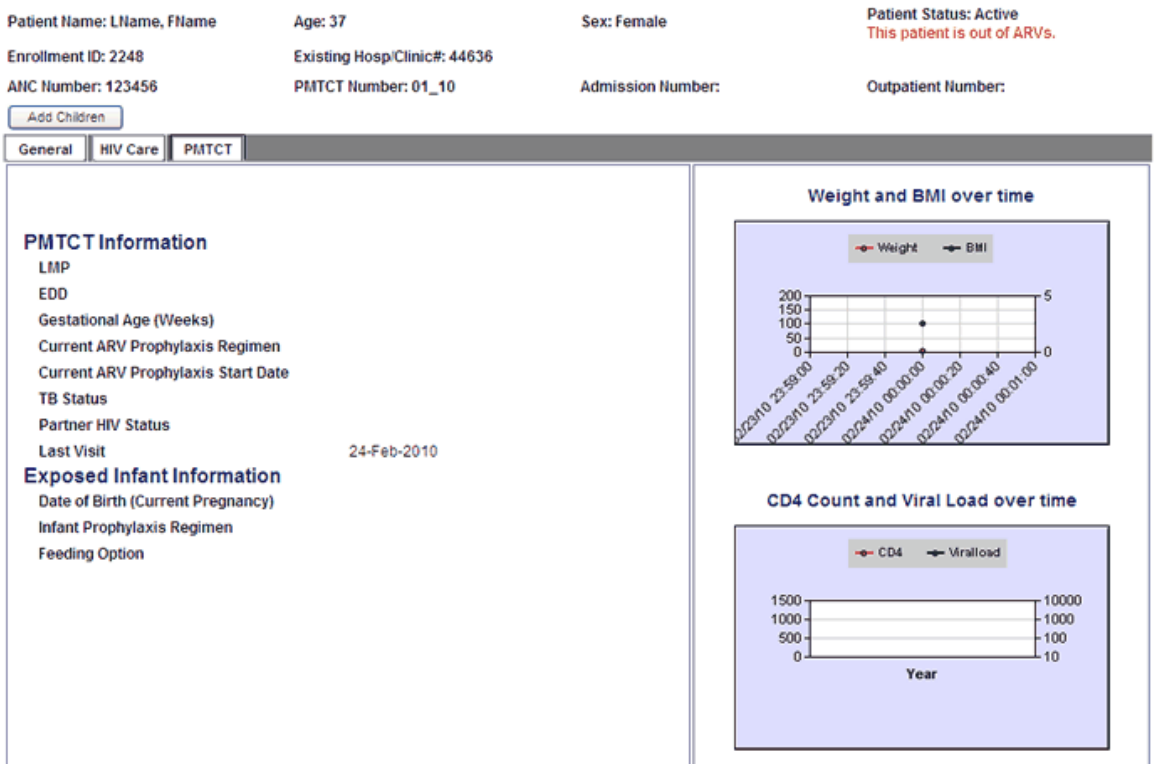

PMTCT TAB	
PMTCT Information (note that this section if for the mother only. If this is a patient home page for a child, this section will be blank)	
LMP	Display the first time LMP is reported from the ANC form
EDD	Display the first time EDD is reported from the ANC form
Gestational Age (Weeks)	Display the more recent gestational age from the ANC form
Current ARV Prophylaxis Regimen	Adult Pharmacy form Display the last ARV regimen within the reporting period With the prophylaxis box checked AND Treatment program = PMTCT
Current ARV Prophylaxis Start Date	Adult Pharmacy form Display the date for the first ARV regimen dispensed With the prophylaxis box checked AND Treatment program = PMTCT
TB Status	Display the TB Status from the ANC form
Partner HIV Status	Display from any form, starting with the most recent if NOT NULL

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Exposed Infant Information	
Date of Birth (Current pregnancy)	Display L&D Delivery Date from the latest L&D
Infant Prophylaxis Regimen	Pediatric Pharmacy form Display the last ARV regimen within the reporting period With the prophylaxis box checked AND Treatment program = PMTCT
Feeding Option	Display the latest feeding option for any register
Test	Display the test name – PCR or Rapid Test
Date	Display the Ordered by Date (note that this has changed from the past- because this test can take a long time to complete and ordered by date is more accurate)
Age (Mnt)	Display the age as of the ordered by date for the test Display the age in months. If less then one month, display a decimal value.
Result	Display the test result; values can be Positive, Negative or Indeterminate

6.2 Universal Registration Form

The universal registration captures contact information about the client/patient that all technical areas/ programs are likely to capture. This form must be filled in and saved before any other data can be captured.

Facts:

- There is only one registration form for the system. It is recommended to create separate technical area enrollment forms that match the data collection needs of the technical area.
- The registration date is different and separate from the enrollment date for a technical area. The registration date is found in the registration form; an enrollment date for a technical area is collected in the Select Technical Area screen. Each technical area has its own enrollment date.
- Fields in the top section of the form cannot be changed or configured.
- Fields below the top section can be configured in IQCare Management under Configure Registration Form
- The form cannot be saved until the you have also selected the technical area, enrollment date and patient identifier (in the Select Technical Area screen)
- The saved registration form can be accessed for update in the patient level navigation under the Registration link
- Any changes to the registration form data will overwrite the existing data.
- No data history is kept for this form.
- See Universal Registration Form Data Dictionary section form more details about pre-defined fields

Other Enrollment Forms:

- The HIV Care Enrollment form which is part of the HIV Care Static form set is a companion form to the Registration form. If the HIV Care Static Form Set technical area is turned on, then this enrollment form will be available in the patient level navigation under the Registration link and in the View Existing forms page.

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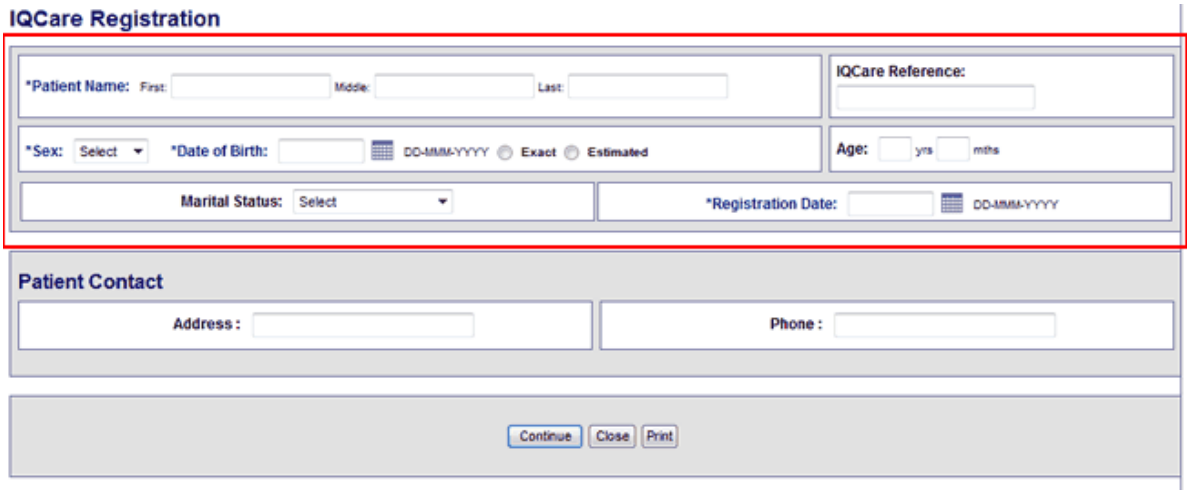
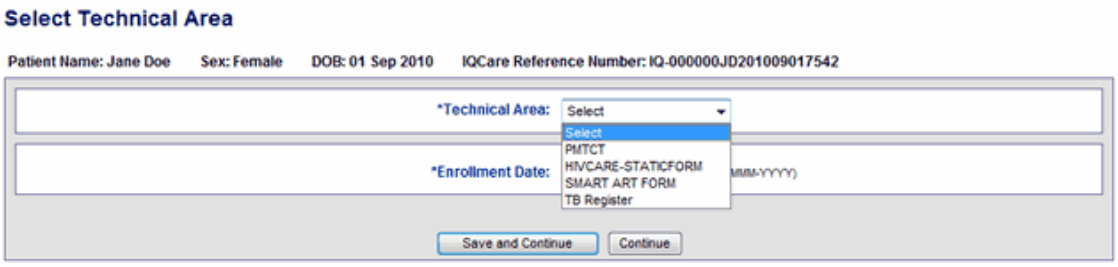
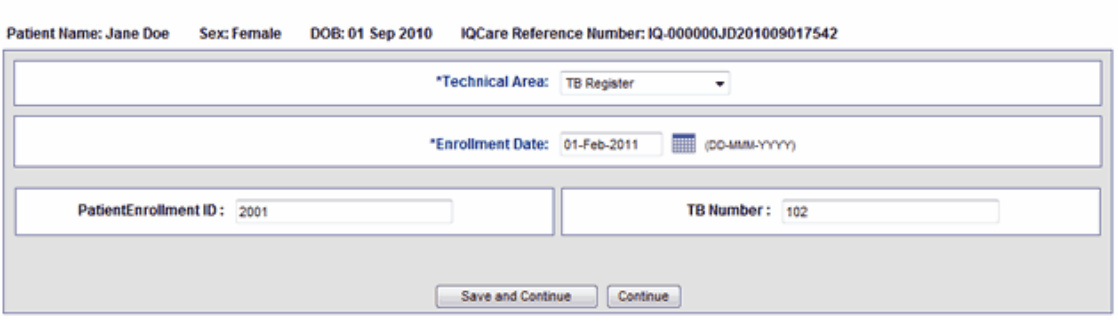


6.3 Select Technical Area

- Assigning patients to a technical area
  1. After registering a patient/client or upon selecting a patient/client from the Find/Add page, the Select Technical Area page displays. Select the technical area and enter the enrollment date and the patient numbers.



  2. The enrollment date and patient numbers change according to the technical area selected.


Select Technical Area
Patient Name: Jane Doe Sex: Female DOB: 01 Sep 2010 IQCare Reference Number: IQ-000000JD201009017542
*Technical Area: TB Register
*Enrollment Date: 01-Feb-2011 (DD-MMM-YYYY)
PatientEnrollment ID : 2001
TB Number : 102
Save and Continue Continue

- Why must you select a technical area every time you want open the patient home page?

  By selecting the technical area before entering the patient home page, the technical area variable is set. Any services (clinician consultation or lab test) and/or any drugs dispensed are assigned to the technical area selected. Furthermore, the navigation display such as the available forms to

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fill in is driven by the technical area.

6.4 Patient Status Rules

Program Status
The patient program status, Active or Care Ended is found in the upper right part of the screen. If the patient has the status of Care Ended, then a Reactivate button is displayed and available for the patient to be re-activated.

Patient Status
Patient status shows the status of the patient in the system. The status types and business rules are as follows:.

Status	Business Rule
Non-ART	If the patient has never had a pharmacy form with ARVs dispensed AND the Treatment Program = ART AND Patient is not care ended (If the patient has had a pharmacy form with ARVs dispensed then the Treatment program can not be ART. The Treatment Program could be PMTCT, PEP, Palliative)
ART	If the patient's last pharmacy form with ARVs dispensed + longest duration + 90 days < =today's date And Treatment program = ART And the patient does not have a Care Tracking form with ART Ended = Yes
Stopped	If the patient has a Care Tracking form with ART Ended but still in care = Yes
Due For Termination	If the patient's last pharmacy form with ARVs dispensed + longest duration + 90 days > today's date And Treatment program = ART And the patient does not have a Care Tracking form with ART Ended = Yes
Care Ended	If the patient is Care Ended, not only does his patient status Care End, his ART/Palliative status Care Ends

Out of ARVs Alert
If a patient has an ART status and is receiving ARVs then IQCare alerts the User if the patient is out of drugs and should return to the facility. "This patient is out of ARVs" is prominently displayed under the patient status.

6.5 Registration Link

The Registration links brings you to the universal registration form for the patient you have selected. This is quick way to get to the patient's contact information.

- Any changes to the registration form data will overwrite the existing data.
- No data history is kept for this form.

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- Another way to view the Registration form for a patient is to use View Existing Forms.
- If the HIV Care Static Forms are active, then the HIV Care Enrollment form will also be available as a selectable option from the Registration link.

6.6 Patient Transfer

The Patient Transfer form allows you to transfer a patient from one location to another. Any treatment performed in the previous location will continue to be tagged with the location where the treatment was actually given. Once a patient is transferred to a new location, IQCare changes the focus and you can not enter any more patient data for that patient with the currently logged-in location. You must log out and re-log in to the transferred location. This process is required so that the correct location of where the patient received treatment is captured correctly.

Transfer Rules

- The Transfer Date must be equal to or greater than the latest visit date. For example, if the latest form (last form fill out) is June 1, 2008, then the Transfer Date must be June 1, 2008 or greater

- Note that for patient transfers on the same date as the visit date, the workflow sequence is very important.
  - For example, if you transfer a patient from location 1 to location 2 first, then the application will require you to log in with location 2 to fill out clinical forms. This means that the clinical forms for that day will be associated with location 2.
  - If you fill in clinical forms for the patient in location 1 and then transferred the patient from location 1 to location 2, then the clinical forms for that date will be associated with location 1.

- Once you have performed a transfer, you can not edit the transfer location. If you have made a mistake, you must login to the transfer location and perform another Patient Transfer for that patient. This would include the situation where you accidentally transferred the wrong patient. In this case you would transfer the patient back to the original location from the new location.

- You can edit existing forms from any location and the data will correctly be associated with the location where the treatment was given.
  - For example, if the patient is in a location 1 and you enter form data for treatment at location 1 (such as a follow-up or lab form) then the patient is transferred to location 2, the data will continue to be associated with location 1. Furthermore, if you log-in to location 2 and realize that there was an error to an existing form associated with location 1 and you make changes to the existing form, when you save the updates, the form continues to be associated with location 1 (where the treatment was given.)

6.6.1 Transferring Patient with National Patient Numbers

For countries with a national patient numbering system, such as Tanzania and Rwanda, when a patient transfers from one location to another the patient keeps his/her patient number for life. This is not the case with other AR countries - a patient is given a new number each time they transfer.

In order to keep the patient number with the patient when they start treatment in a new in countries that have a national ID number, you do not enter them as a new patient at the new location but you must transfer them in to the new location.

In IQCare, for transferred in patients, you must first register the patient at the “previous” location with their original patient number to establish the correct patient number and then transfer the patient using

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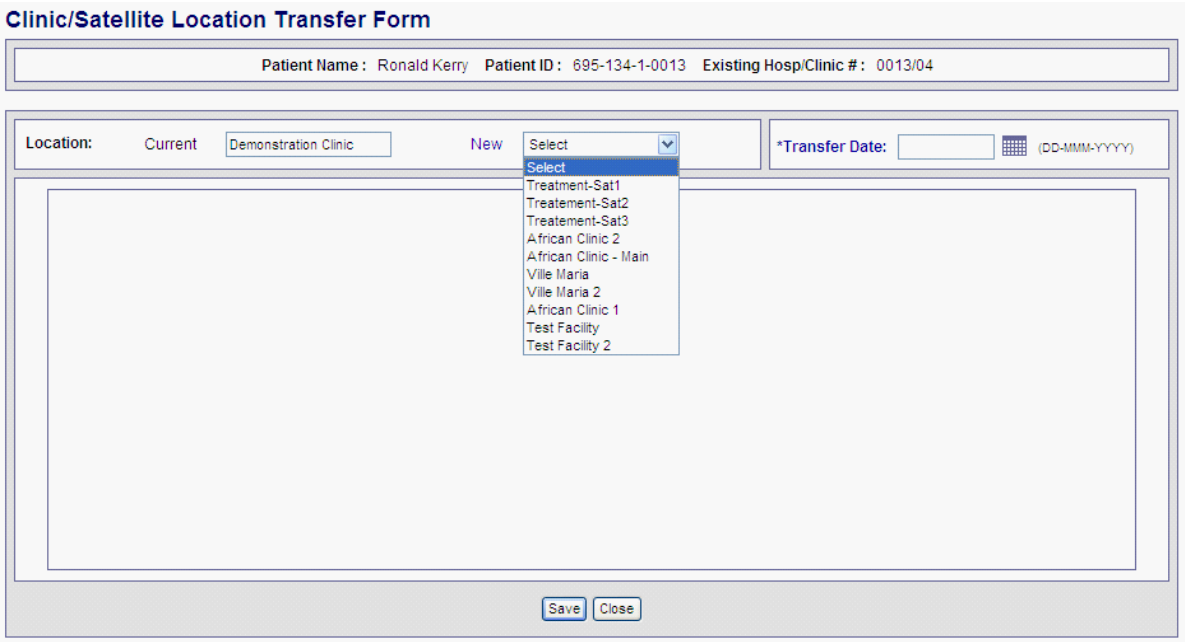
the Patient Transfer feature, to the location where the patient is getting treatment.

For example, suppose a patient is at Bombo Hospital and given this patient number upon enrollment: 04-04-0100-01089. Then six months later the patient transfers to Muheza. You are the data entry clerk at Muheza and need to enter this transferred in patient.

1. Login with Bombo Hospital
2. Use the Find/Add Patient, Add a patient by registering the patient with the number he was given at Bombo Hospital 04-04-0100-01089
3. From the patient home page, click on Patient Transfer and select Muheza in the Transfer To list.
4. Log out
5. Login with Muheza
6. Use the Find/Add Patient to search for the patient
7. Create a patient record, lab order, pharmacy, follow up information, etc.

6.6.2 Transfer a Patient

1. Select Patient Transfer from the patient level navigation
2. Select the new location and enter the transfer date
3. Click Save



6.6.3 Edit Patient Transfer Information

1. Select Patient Transfer from the patient level navigation
2. Select the location you would like to edit from the locations in the table; the data will display in the fields above the table.
3. To change the current location, select a new location. The change the transfer date, enter in a new date.

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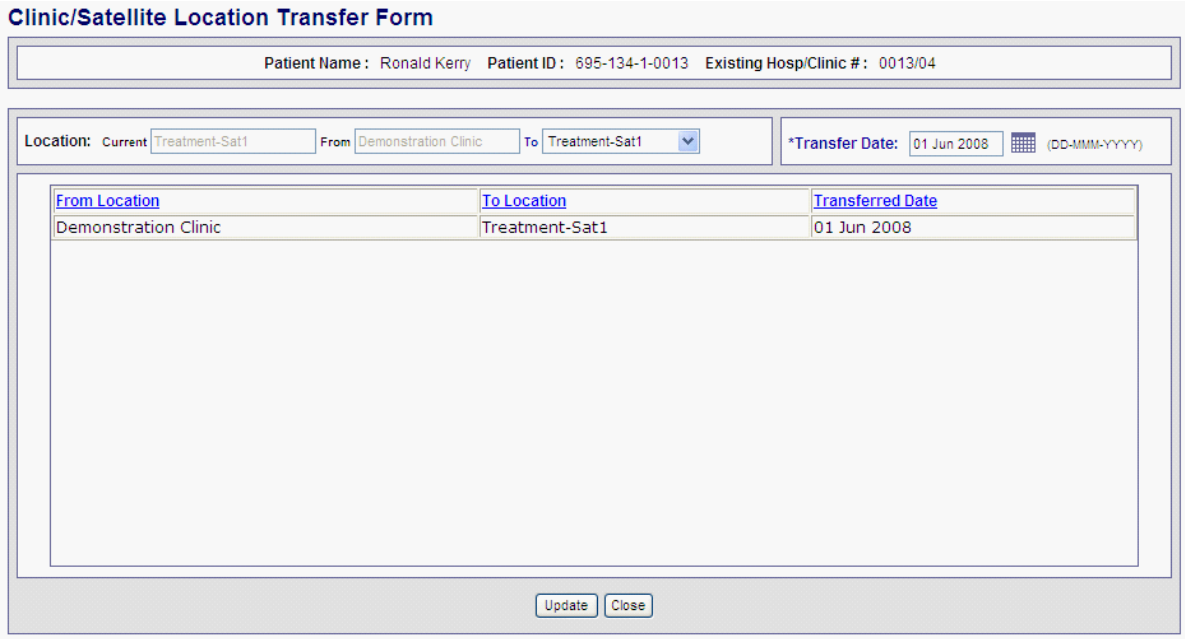
4. Click Update



6.7 Additional Forms

Under the additional forms navigation link is the Family Information and Follow up Education links. These forms are adjunct forms that may be optional to use depending on your data collection process.

6.8 View Existing Forms

You can view all of the previously filled in forms for a patient by clicking on the View Existing Forms link. If there are existing forms, they are displayed in reverse chronological order by year and then by month. The current year is displayed so that all of the forms for that year are easily visible. To see all other earlier years you must click on the "+" sign to open the year view and then again to open the month view. Clicking on the "-" sign closes a month or year.

Next to each form is the Data Quality Check indicator.

A form that has been checked for data quality has a green check mark beside it.

A form (paperless mode) that needs to be completed has a yellow exclamation mark beside it.

A form that has not been checked for data quality has a red X mark beside it.

Click here for more information about the Data Quality Check.

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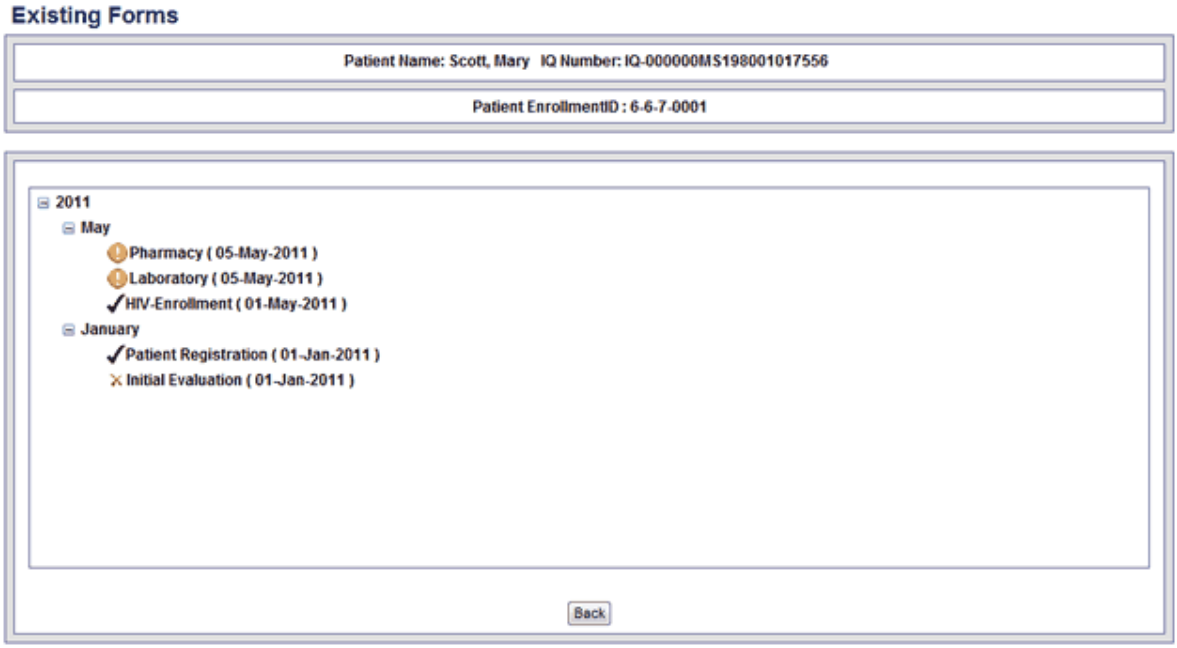

6.9 Create New Form/Additional Forms

When you hover over the Create New Form navigation label, the list of forms you can fill in is displayed. Upon clicking a form name, an empty version of the form is displayed.

▼ **HIV Care Static Form Set**

Note that if an Initial Evaluation Form is not filled in, then you can not create an ART or non-ART Follow-up form.

The following clinical forms can be found under the Create New Form link

- Initial Evaluation
- Adult Pharmacy
- Paediatric Pharmacy
- Laboratory Order
- ART Follow-up
- Non-ART Follow-up
- Home Visit
- Care Tracking

Under Additional Forms link:

- Family Information

6.10 Reactivating a Patient

On the Contact Tracking form if the question “Patient care-ended?” =”Yes” with a care-ended date, then upon saving the form, the system changes the patient status from “Active” to “Care Ended”.

A patient can be re-activated if their status is Care-Ended. Re-activation is a manual procedure. To re-activate a patient, click on the Reactivate button found on the patient home page.

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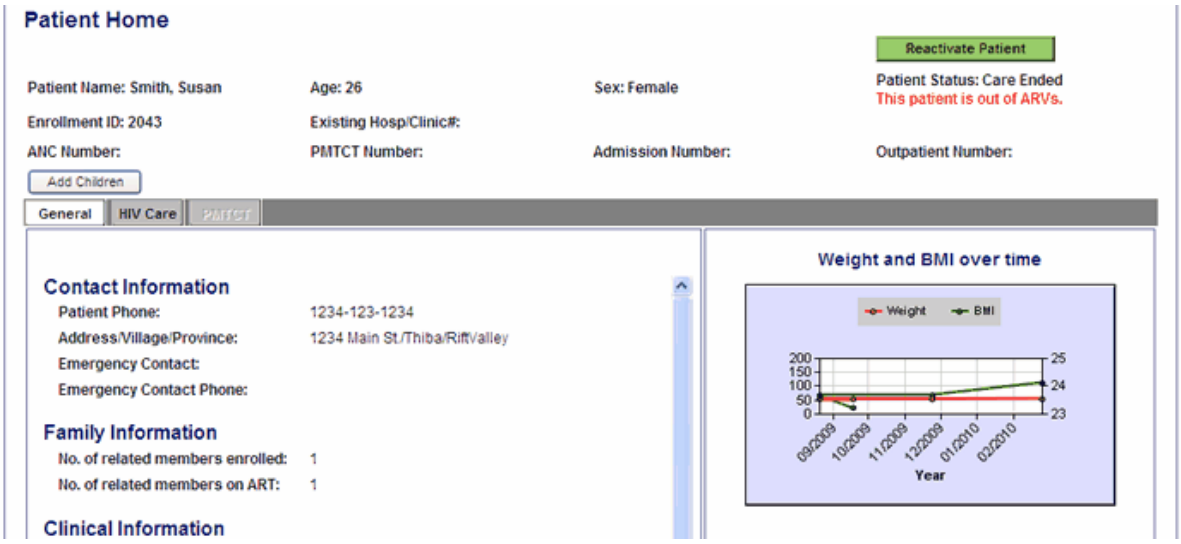

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Part VII

7 Pre-Defined Reports

IQCare has four different categories of reports – Patient, Facility, Donor and Custom reports. The Patient, Facility and Donor reports are reports that have been pre-formatted and specific business rules are executed when the reports are run. The Custom reports allow you to configure your own reports from all of the data available in IQCare. The Facility, Donor and Custom report links are found in the Facility level navigation; the Patient reports link is found in the Patient level navigation.

All facility reports and Donor reports are location dependent and only display data for the logged-in location. However, Custom reports also uses data from the entire database, unless a location is specifically chosen as part of the custom report query.

Report results can be saved to Excel.

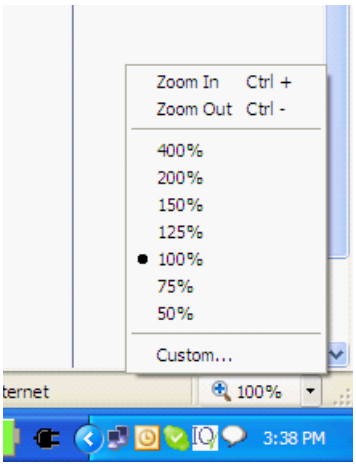
7.1 Adjusting Report Display Size

Some of the reports use a specific and pre-defined Excel template, such as the Track 1.0 and NACP Monthly and Quarterly reports. These templates use large fonts and the initial display is too large. By using the zoom feature in your browser or Excel, the report with correctly and can be read easily.

Changing Display Size in Internet Explorer
Internet Explorer Zoom lets you enlarge or reduce the view of a webpage. Unlike changing font size, zoom enlarges or reduces everything on the page, including text and images. You can zoom from 10% to 1000%.

To zoom a webpage

- On the bottom right of the Internet Explorer screen, click the arrow to the right of the Change Zoom Level button.



- If you have a mouse with a wheel, hold down the CTRL key, and then scroll the wheel to zoom in or out.
- From the keyboard you can increase or decrease the zoom value in 10% increments. To zoom in, press CTRL+PLUS SIGN. To zoom out, press CTRL+MINUS SIGN. To restore the zoom to 100%, press CTRL+0.

Changing Display Size in Excel 2003 and 2007

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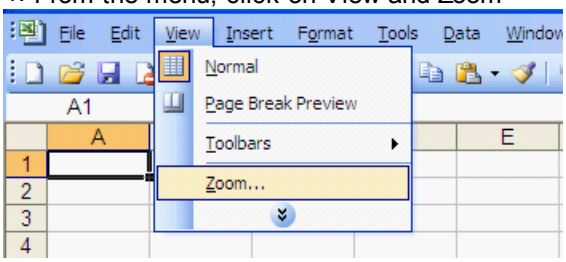
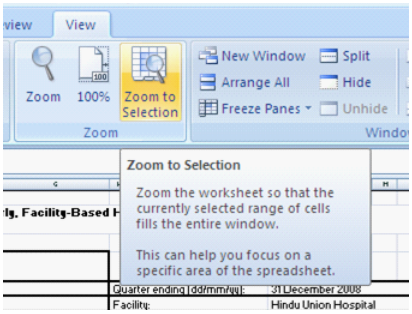
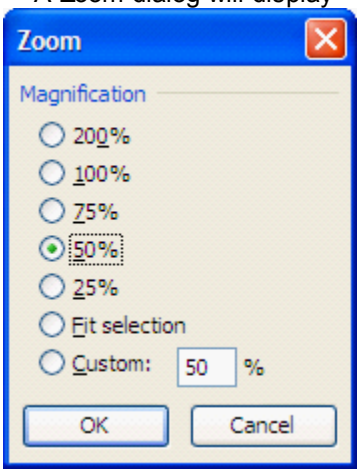
1. From the menu, click on View and Zoom





2003 Excel **2007 Excel**

2. A Zoom dialog will display



3. Select the zoom level of 50% for the best display of the Track 1.0 and NACP reports.

7.2 Patient Reports

There are two pre-defined patient reports available in IQCare.

ARV Pick-up Report
Patient Profile Report

7.2.1 ARV Pick-up

How the report is calculated
For details on how this report is calculated, please see the Facility ARV Pick-up report section.

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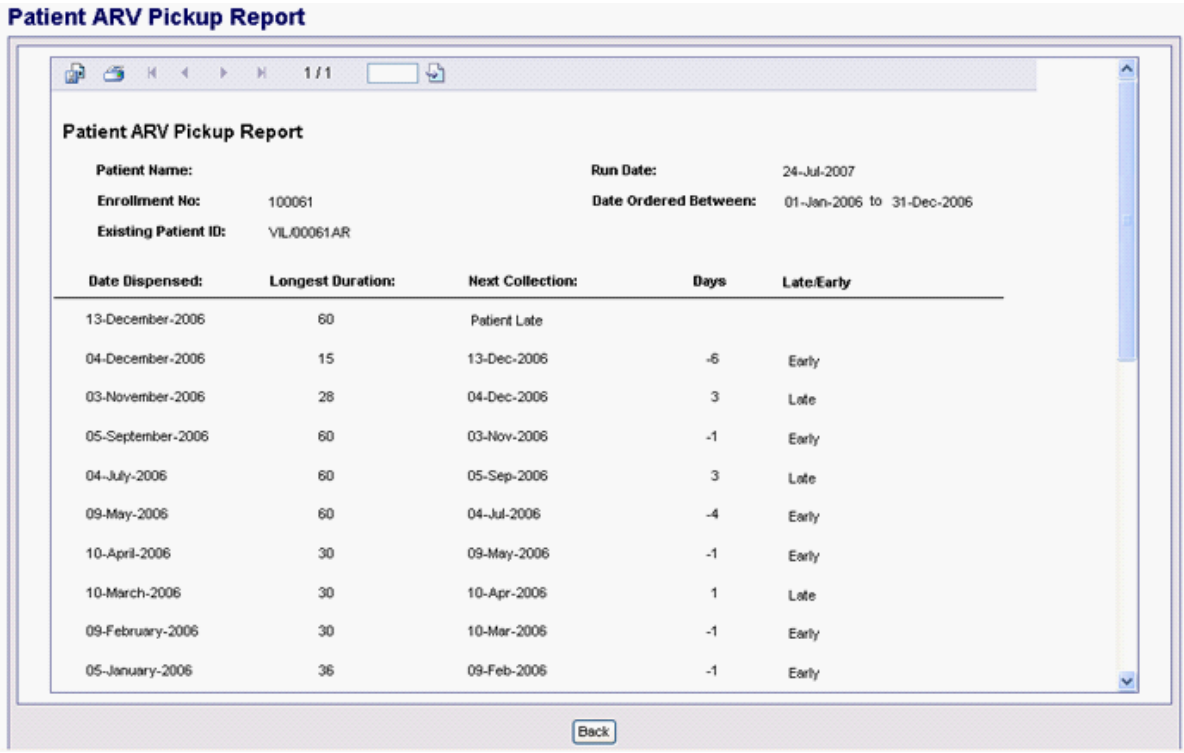
Run the Patient ARV Pick-up Report

1. From the Patient level navigation, select Patient Reports/Patient ARV Pickup
2. Enter the date range for the report

3. Click the Submit button.


Patient ARV Pickup Report
1 / 1
Patient ARV Pickup Report
Patient Name:
Run Date: 24-Jul-2007
Enrollment No: 100061
Date Ordered Between: 01-Jan-2006 to 31-Dec-2006
Existing Patient ID: VIL/00061AR
Date Dispensed: Longest Duration: Next Collection: Days Late/Early
13-December-2006 60 Patient Late
04-December-2006 15 13-Dec-2006 -6 Early
03-November-2006 28 04-Dec-2006 3 Late
05-September-2006 60 03-Nov-2006 -1 Early
04-July-2006 60 05-Sep-2006 3 Late
09-May-2006 60 04-Jul-2006 -4 Early
10-April-2006 30 09-May-2006 -1 Early
10-March-2006 30 10-Apr-2006 1 Late
09-February-2006 30 10-Mar-2006 -1 Early
05-January-2006 36 09-Feb-2006 -1 Early
Back

4. If the report spans more than one page, use the arrow buttons to move from forward and backwards.
5. To print the report, click the printer icon; to save the data to Excel, click the spreadsheet icon.
6. To re-run the report with a different date range, click the Back button and re-enter the date range.

7.2.2 Patient Profile

This report provides a snapshot of the patient's history while in the program. The primary use for this report is to provide patients with a record of their previous treatment with the clinic, should they move to another clinic.

There are five sections the make up the Patient Profile report:

Report Section	Data Origination

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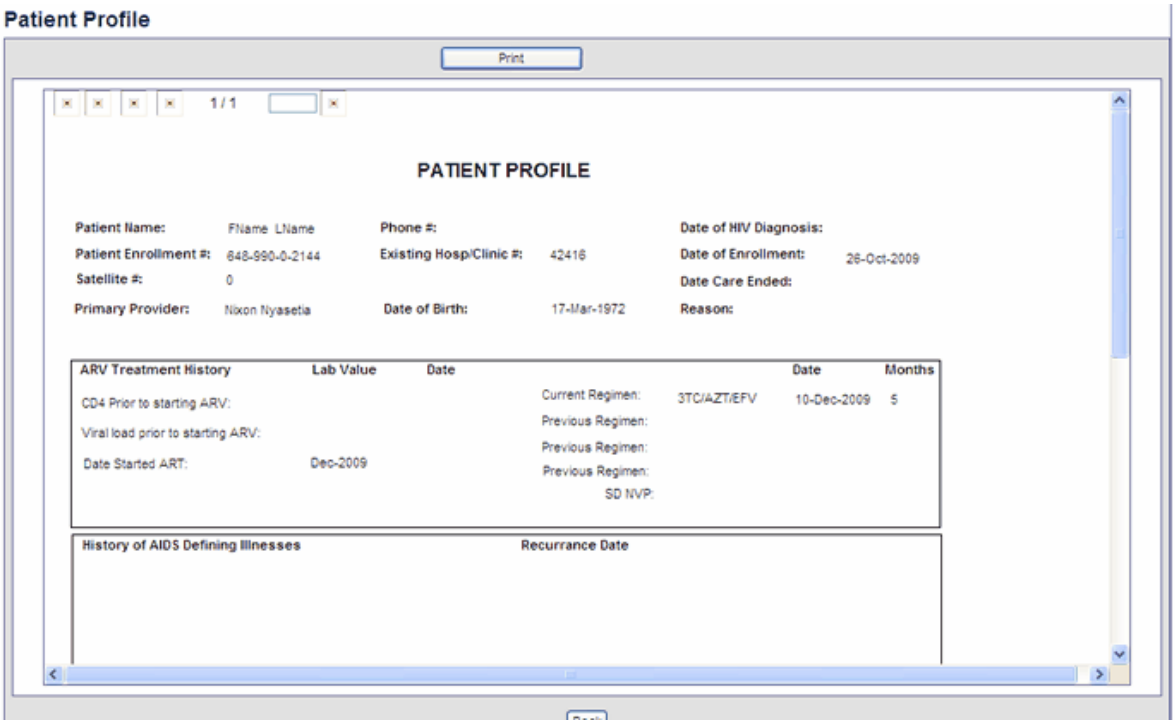
Patient demographics	Enrollment form
ARV Treatment History	Initial Evaluation form
History of AIDS Defining Illness	Initial Evaluation and ART or Non-ART Follow-up forms
Laboratory History	Lab: Lab Order form
Weight History	Weight: Initial Evaluation and ART or Non-ART Follow-up forms

Running a Patient Profile Report

1. From the Patient level navigation, select Patient Reports/Patient Profile
2. The report will run and display; you can print the report in a .pdf format



7.2.3 Kenya MOH 257 Blue Card

The Kenya MOH 257 Blue Card is available via the patient navigation under Patient Reports. The Blue Card is a summary of different form data coming from the AIDSRelief form set. IQCare generates an Excel file that contains four sheets: “TechnicalNotes” , “MoH257Reg”,” MoH257Visits” and “MoH257Educ” . Follow this link for the Blue Card template.

Note also that at the same time the Blue Card template is being filled with the selected patient's data, an HL7 message document is also created. This message can be used to transfer patient data from one IQCare database to another or from IQCare to another EMR (Electronic Medical Record) application. (See International Standards for more information)

Although this is a Kenya report, this report will be available to all countries as a patient report.

Running a Kenya MOH 257 Blue Card Report

1. Search and find a patient

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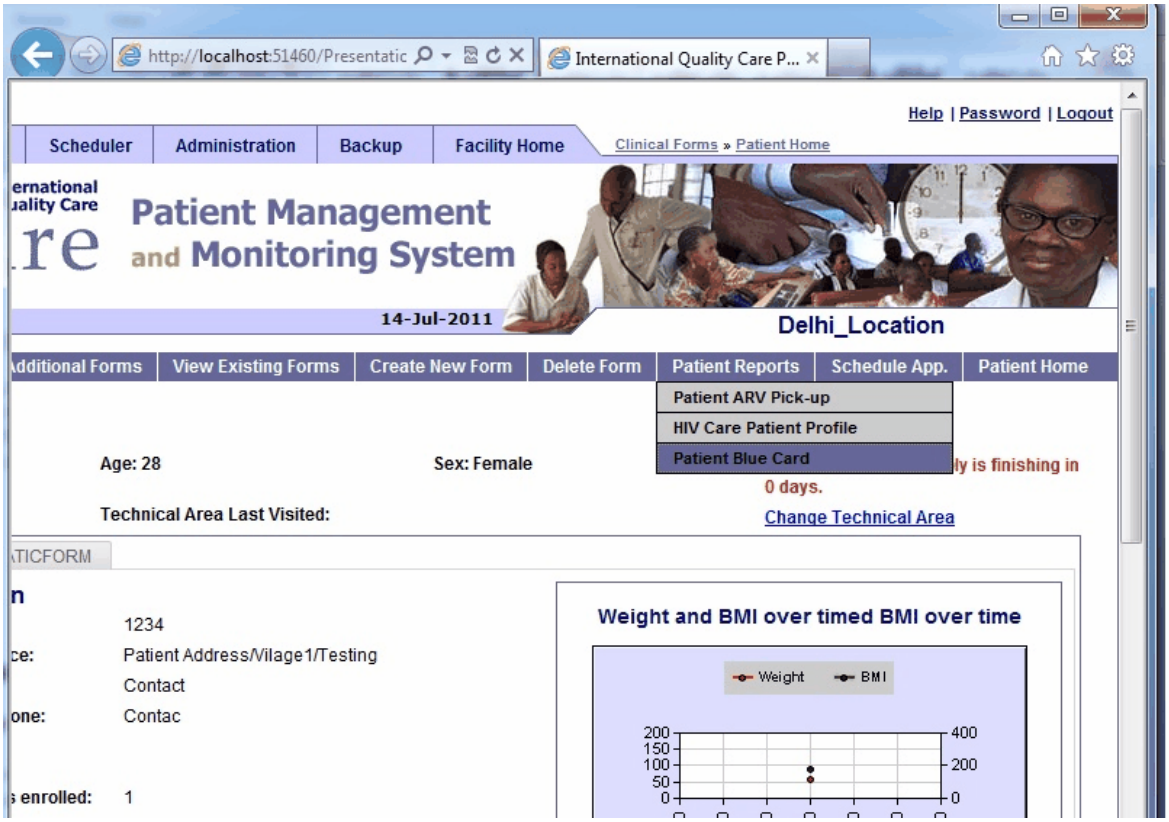
2. Under Patient Reports, select Patient Blue Card
3. IQCare runs the report and displays a Windows dialog asking the User to open or save the file.



7.3 Facility Reports - HIV Care

HIV Care facility reports available in IQCare

ARV Pick up - Displays the patient and number of days since the last pick up of ARVs. Helps identify patients that have not returned to pick up ARVs.
Missed ARV Pick up - A variant of the ARV Pick up report; helps identify patients that have not returned to pick up ARVs.
Patient Enrollment by Month - Displays the number of new patients enrolled by month
Quality Assurance - Displays the number of forms created by user name

7.3.1 ARV Pick-up

How the ARV Pick-up Report is Calculated
This facility report displays the ARV pick-up history, sorted by patient. This same report with the same calculations is available on a per patient basis from the Patient Home Page.

This report helps determine a pattern of pick up for a particular patient. This report is based on the data found in the adult or paediatric pharmacy forms: dispensed by date and the longest duration of all of the ARV drugs dispensed within a pharmacy form.

Most Recent ARV Pick-up (the top line for each patient)
The top line for each patient will say either “Patient Late” or Patient Not Yet Due”. For the patient

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100061 patient example below, because this report was run in July 2007 and the data set used to run this report stopped in February 2007, the top line is displaying “Patient Late”. When you run this for your facility with current data, you should only see “Patient Late” when the patient is truly late picking up his/her ARVs otherwise you will see the text “Patient Not Yet Due”

Calculating Late or Early
To calculate if an ARV pick up is late or early, you do the following:
Determine the number of days between the most current date dispensed and the previous dispensed by date. Then subtract the longest duration of ARV drugs dispensed.

Calculation Examples for Patient 100061. Please see chart below.
December 13th was the most current dispensed by date; December 4th, the previous dispensed by date and 15 days is the longest duration.

The number of days between December 4 and December 15 is 9 days
There where 15 days of drugs dispensed. 9 -15 = -6 days (extra drugs) – so the patient was early by 6 days

Moving to the next line…December 4th was the current pick-up date and November 3rd the previous pick-up date. 28 days of drugs were dispensed.

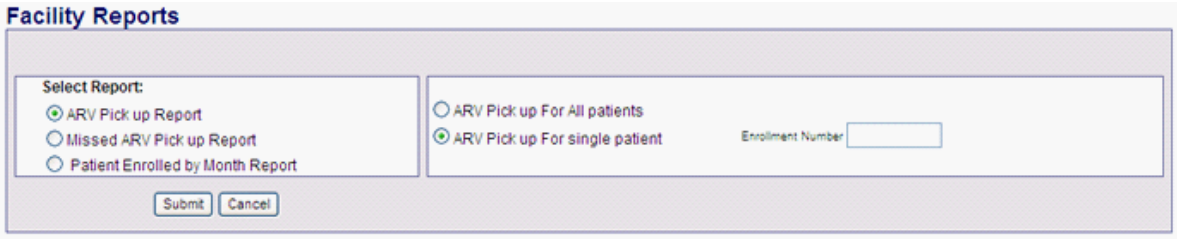
The number of days between November 3rd and December 4th is 31 days. (27 days in November and 4 days in December = 31 days)
There were 28 days of drugs dispensed. 31-28 = 3 days (without drugs)

ARV Pick-up Example for Patient 100061

13-Dec-2006	100061	60	Patient Late		
04-Dec-2006	100061	15	13-December-2006	-6	Early
03-Nov-2006	100061	28	04-December-2006	3	Late
05-Sep-2006	100061	60	03-November-2006	-1	Early
04-Jul-2006	100061	60	05-September-2006	3	Late
09-May-2006	100061	60	04-July-2006	-4	Early

Running an ARV Pick-up Report

1. From the Facility level navigation, select Reports/Facility Reports



2. Select ARV Pick up Report and then either the All Patients report or select the single patient

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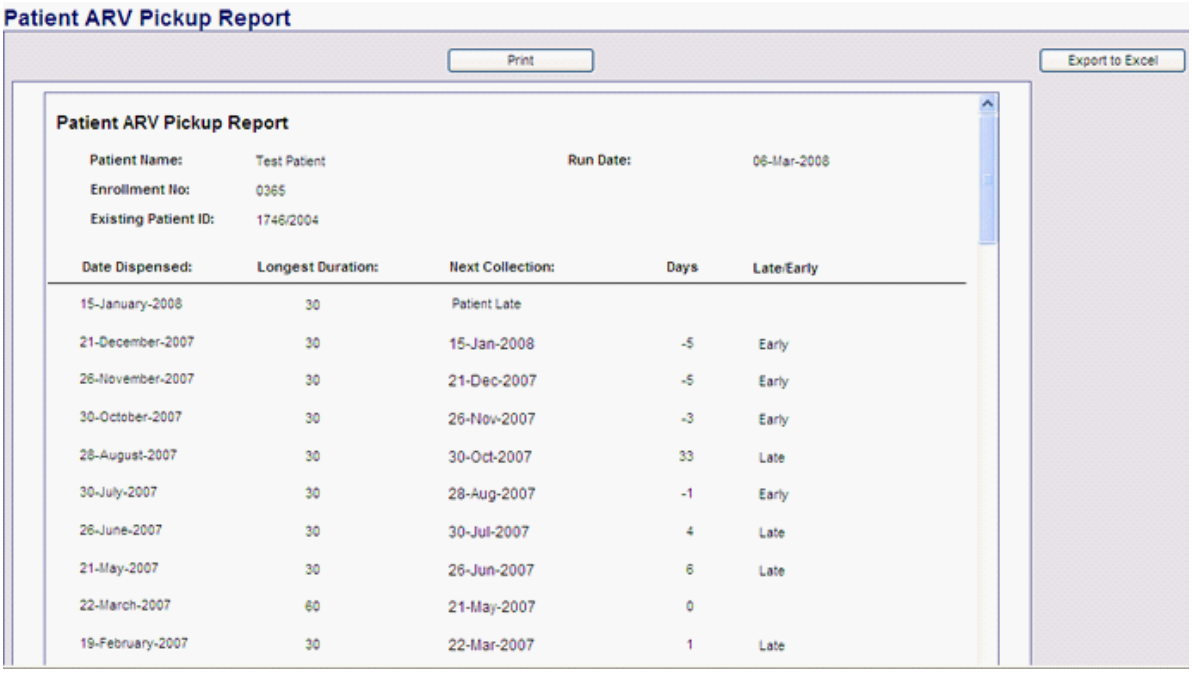
report and enter the patient Enrollment number. Both reports run are run on the full database data from the inception of the database.

3. Click the Submit button.
4. To print the report, click the Print button; to save the data to Excel click the Export to Excel button


Patient ARV Pickup Report
Print
Export to Excel
Patient ARV Pickup Report
Patient Name: Test Patient
Run Date: 06-Mar-2008
Enrollment No: 0365
Existing Patient ID: 1746/2004
Date Dispensed: Longest Duration: Next Collection: Days Late/Early
15-January-2008 30 Patient Late
21-December-2007 30 15-Jan-2008 -5 Early
26-November-2007 30 21-Dec-2007 -5 Early
30-October-2007 30 26-Nov-2007 -3 Early
28-August-2007 30 30-Oct-2007 33 Late
30-July-2007 30 28-Aug-2007 -1 Early
26-June-2007 30 30-Jul-2007 4 Late
21-May-2007 30 26-Jun-2007 6 Late
22-March-2007 60 21-May-2007 0
19-February-2007 30 22-Mar-2007 1 Late

7.3.2 Missed ARV Pick-up

This report helps clinics manage patients that have missed picking up their ARV medication. It is based on the data found in the adult or paediatric pharmacy forms; the dispensed by date and the longest duration of all of the ARV drugs dispensed within a pharmacy form.

How the report is calculated

Report Field Name	Description
Run Date	The date the report is run
Defaulter as of Date	Defaulter as of Date is the date entered by the user. The report will find all patients who have missed their ARV until this date.
Enrol#?	The patient enrollment number
Patient Name?	The patient's first and last name
Age	The current age of the patient
Dispensed by date	Dispensed by Date found on the latest pharmacy form
ARV for (x) days	This is maximum number of days by which patient can be late. This is calculated by looking at the last pharmacy form and looking for

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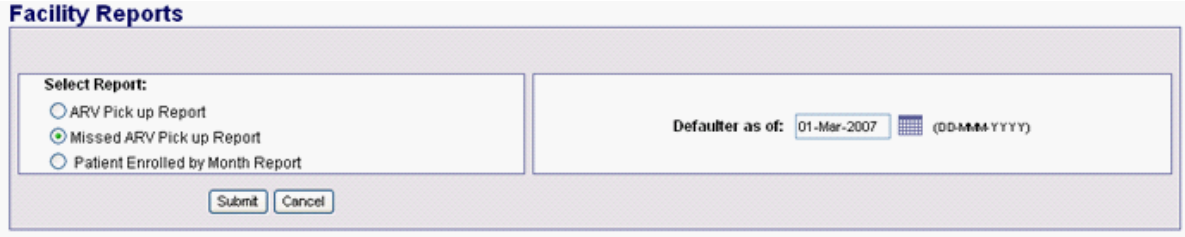
	the longest duration for a dispensed ARV medication.
Expected Return (date)	This is patient's last pharmacy dispensed by date + maximum duration of a dispensed ARV medication. Example:- Patient last pharmacy date is 3-May-2007 and duration was 60 days then expected return would be:- 3-May-2007 + 60 days (max duration) = 2-July-2007
Overdue (days)	This is the number of days between the number of days between the Defaulter's date and the Expected Return date. Example:- User has entered Defaulter's as of = 26-Sept-2007 and expected return date of patient was 2-July-2007 then overdue would be 26-Sept-2007 – 2-July-2007 = 86 days
Termination Status	Shows only Active patients and excludes PEP, PMCT or palliative care patients.

Running a Missed ARV Pick-up Report

1. From the Facility level navigation, select Reports/Facility Reports
2. Select the Missed ARV Pick-up Report
3. Enter the defaulter as of date



1. Click the Submit button.
2. To print the report, click the Print button; to save the data to Excel, click the Export to Excel button.
3. To re-run the report with a different defaulter date, click the Back button and re-enter another date.

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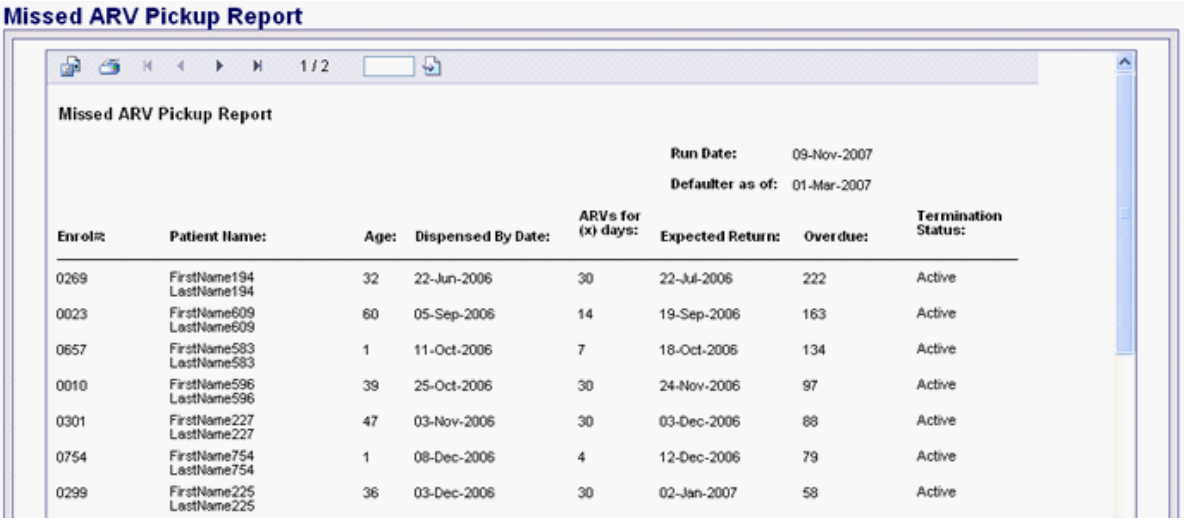
Missed ARV Pickup Report
1 / 2
Missed ARV Pickup Report
Run Date: 09-Nov-2007
Defaulter as of: 01-Mar-2007
Enrol#: Patient Name: Age: Dispensed By Date: ARVs for (x) days: Expected Return: Overdue: Termination Status:
0269 FirstName194 LastName194 32 22-Jun-2006 30 22-Jul-2006 222 Active
0023 FirstName609 LastName609 60 05-Sep-2006 14 19-Sep-2006 163 Active
0657 FirstName583 LastName583 1 11-Oct-2006 7 18-Oct-2006 134 Active
0010 FirstName596 LastName596 39 25-Oct-2006 30 24-Nov-2006 97 Active
0301 FirstName227 LastName227 47 03-Nov-2006 30 03-Dec-2006 88 Active
0754 FirstName754 LastName754 1 08-Dec-2006 4 12-Dec-2006 79 Active
0299 FirstName225 LastName225 36 03-Dec-2006 30 02-Jan-2007 58 Active

7.3.3 Patient Enrolled by Month

The Patient Enrolled by Month report displays the number of patients enrolled on a monthly basis between the specified “From” and “To” dates.

- IQCare ignores the specific day field and calculates the number enrolled for the entire month. For example, if 15-Jan-2006 is entered in the From date field, then the report should include all of January 2006. If 15-Apr-2006 is entered in the To date field, then the report should include all of April 2006.
- If there is zero (0) patients enrolled for a particular month, this information is not be displayed in both the graph and the chart and the month is skipped.

Running a Patient Enrolled by Month Report

1. From the Facility level navigation, select Reports/Facility Reports
2. Select the Patient Enrolled by Month report
3. Enter date range

4. Click the Submit button.
5. The report displays a graph and the associated monthly enrollment numbers
6. To print the report, click the Print button.

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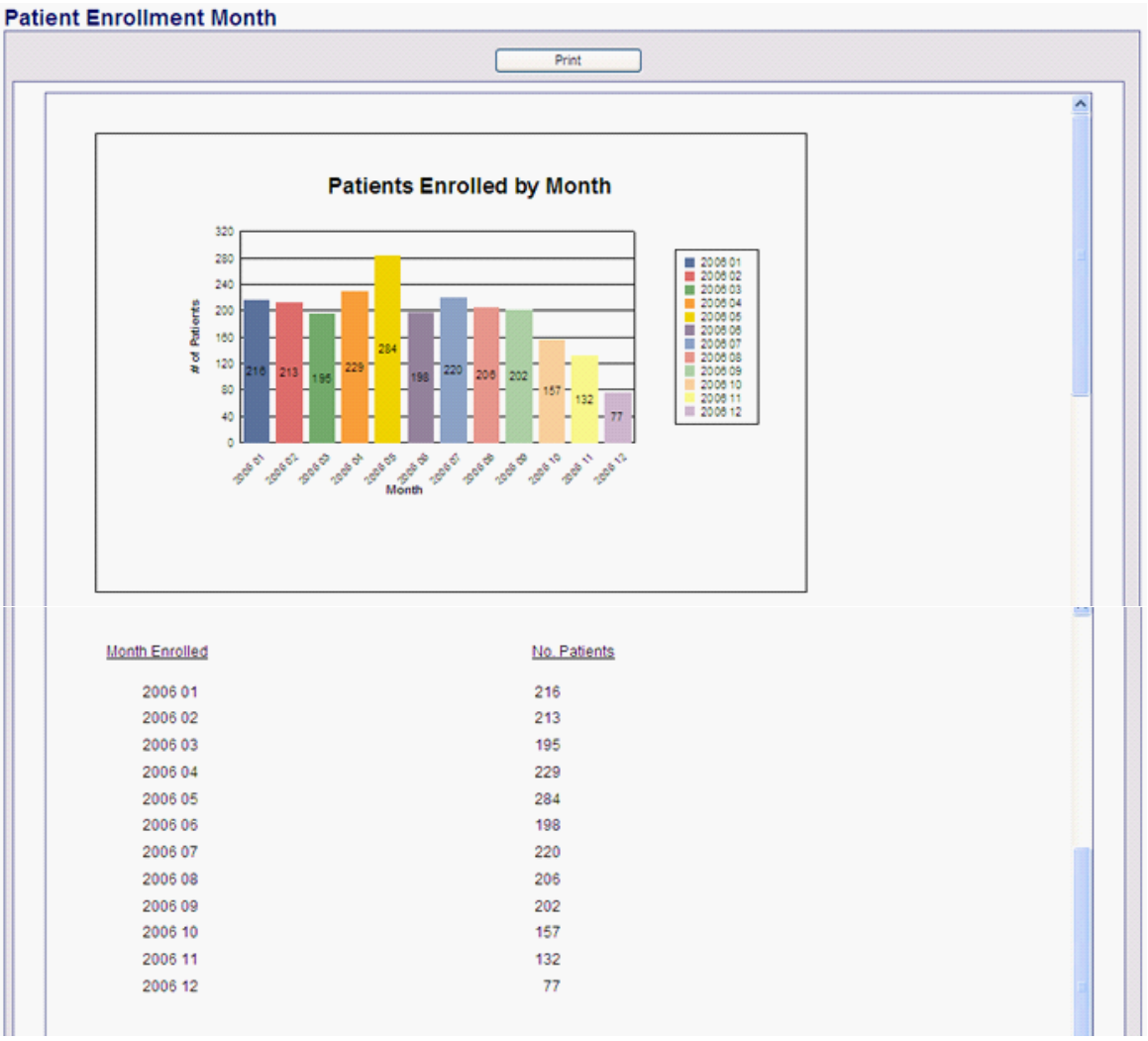

Month Enrolled	No. Patients
2006 01	216
2006 02	213
2006 03	195
2006 04	229
2006 05	284
2006 06	198
2006 07	220
2006 08	206
2006 09	202
2006 10	157
2006 11	132
2006 12	77

7. To re-run the report with a different date range, click the Back button and re-enter the date range.

7.3.4 Quality Assurance

This report is used for two purposes: 1) To show which forms have not been data quality checked and; 2) to show how many forms have been filled out by a data entry clerk or User.

1. From the Facility level navigation, select Reports/Facility Reports
2. Select the Quality Assurance report
3. Enter either a date range and select all users or select an individual user

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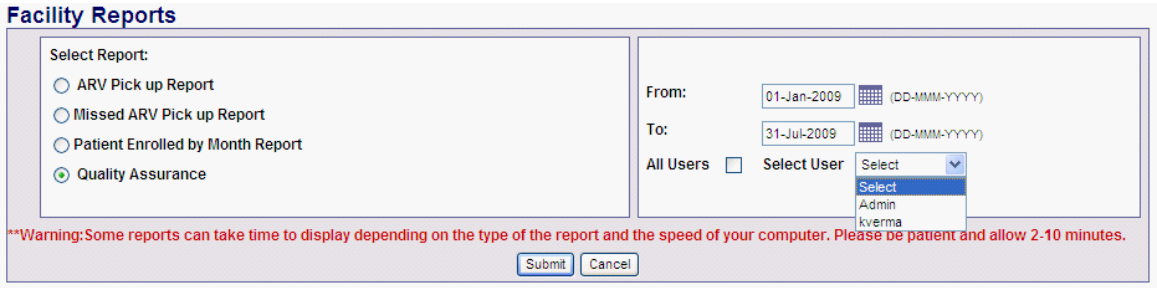
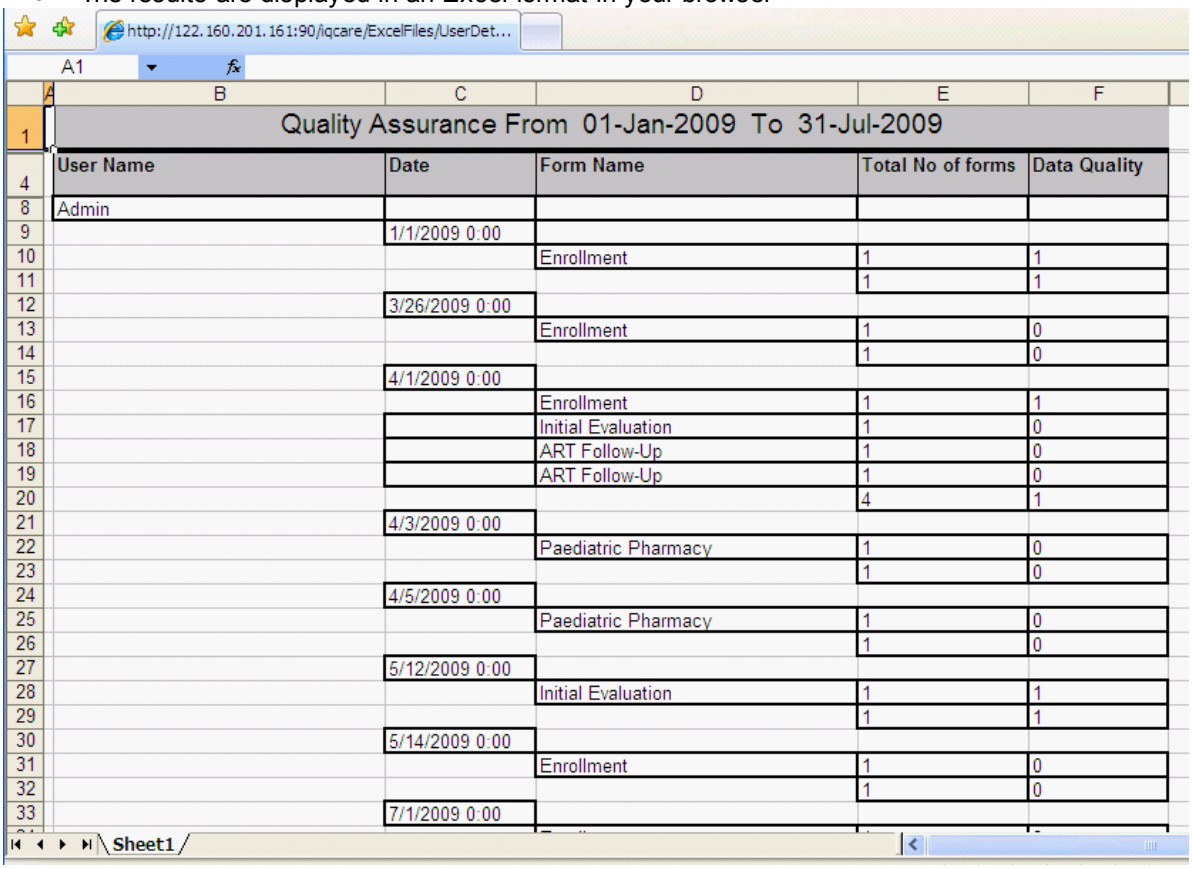


4. Click Submit to run the report
5. The results are displayed in an Excel format in your browser



User Name	Date	Form Name	Total No of forms	Data Quality
Admin				
	1/1/2009 0:00			
		Enrollment	1	1
			1	1
	3/26/2009 0:00			
		Enrollment	1	0
			1	0
	4/1/2009 0:00			
		Enrollment	1	1
		Initial Evaluation	1	0
		ART Follow-Up	1	0
		ART Follow-Up	1	0
			4	1
	4/3/2009 0:00			
		Paediatric Pharmacy	1	0
			1	0
	4/5/2009 0:00			
		Paediatric Pharmacy	1	0
			1	0
	5/12/2009 0:00			
		Initial Evaluation	1	1
			1	1
	5/14/2009 0:00			
		Enrollment	1	0
			1	0
	7/1/2009 0:00			

6. To return to IQCare, click the back button on your browser

7.4 Facility Reports - PMTCT

IQCare provides PMTCT facility reports based on the country.

Kenya

- Born to Live
- NASCOP Monthly Report

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- Kenya National Integrated Form (711B) PMTCT Section

Uganda
- TBD

Nigeria
- NNRIMS Monthly Report

The Quality Assurance report is also available for PMTCT Register forms. This is run in the same way as the HIV Care version.

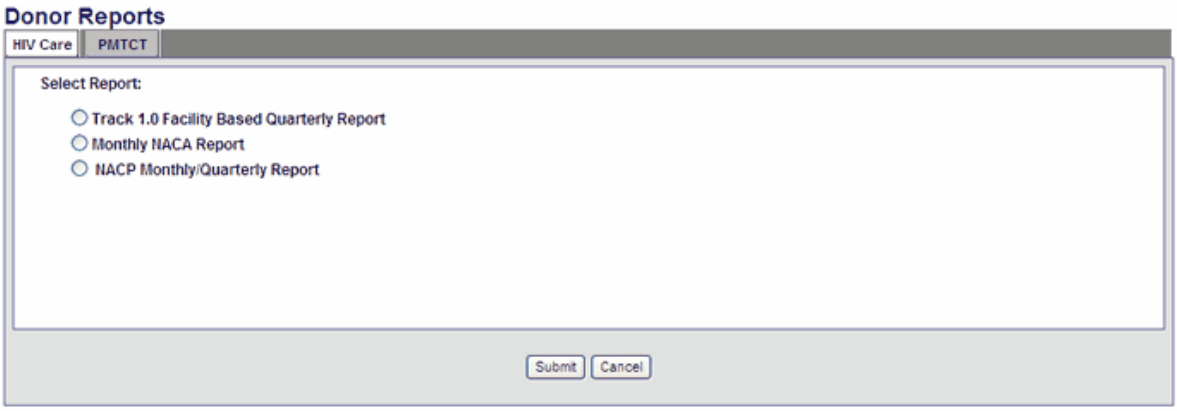
7.5 Donor Reports - HIV Care

HIV Care Donor reports available in IQCare

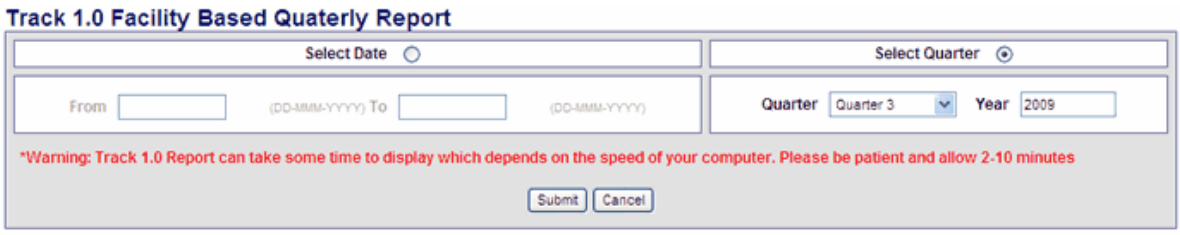
- Track 1.0
- Nigeria NACA Monthly Report

7.5.1 Track 1.0

1. From the Facility level navigation, select Reports/Donor Reports



2. Select the Track 1.0 report and click the Submit button



3. Enter either a specific date range or enter the quarter for which you want the report to run
4. Click the Submit button.
5. Select if you would like to Open or Save the file
6. The report displays using the CDC Track 1.0 Excel template. To reduce the size of the spreadsheet, hold down the control key and move your mouse wheel toward you.
7. To return to IQCare, use the browser back button.

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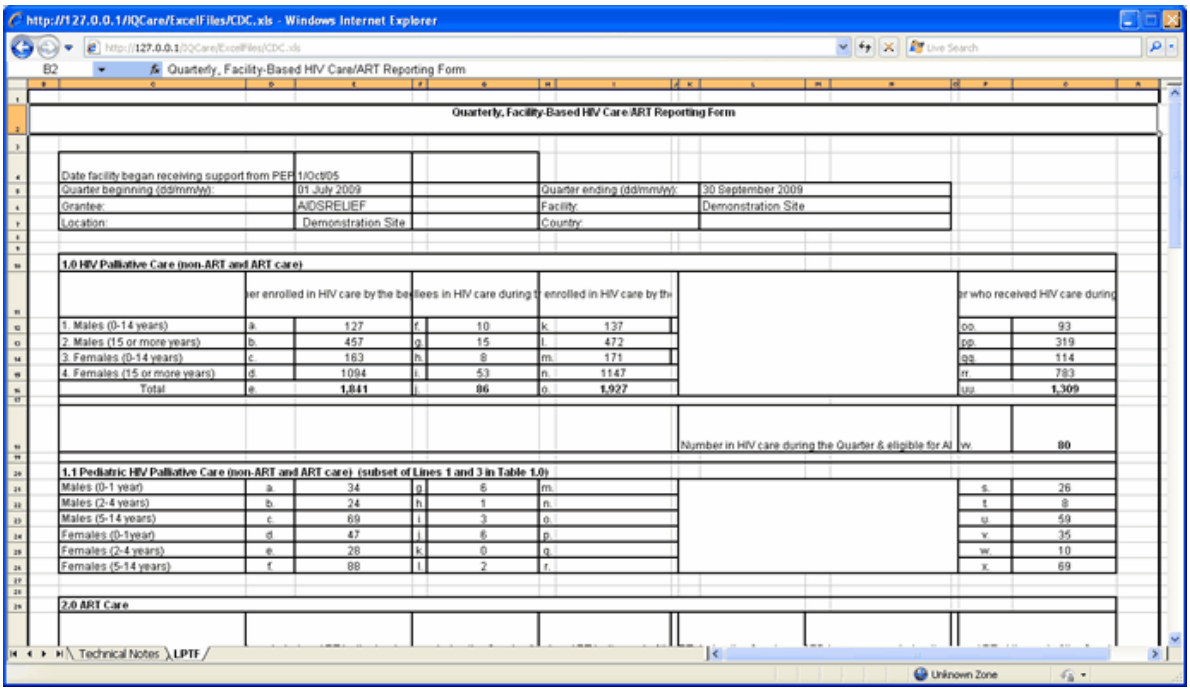

7.5.2 Nigeria NACA

1. From the Facility level navigation, select Reports/Donor Reports

2. Select the Nigeria Monthly NACA Report and click the Submit button

3. Enter either a specific date range (month and year) for the report; to run the report for one month only, enter the same month in the From and To fields.
4. Click the Submit button.

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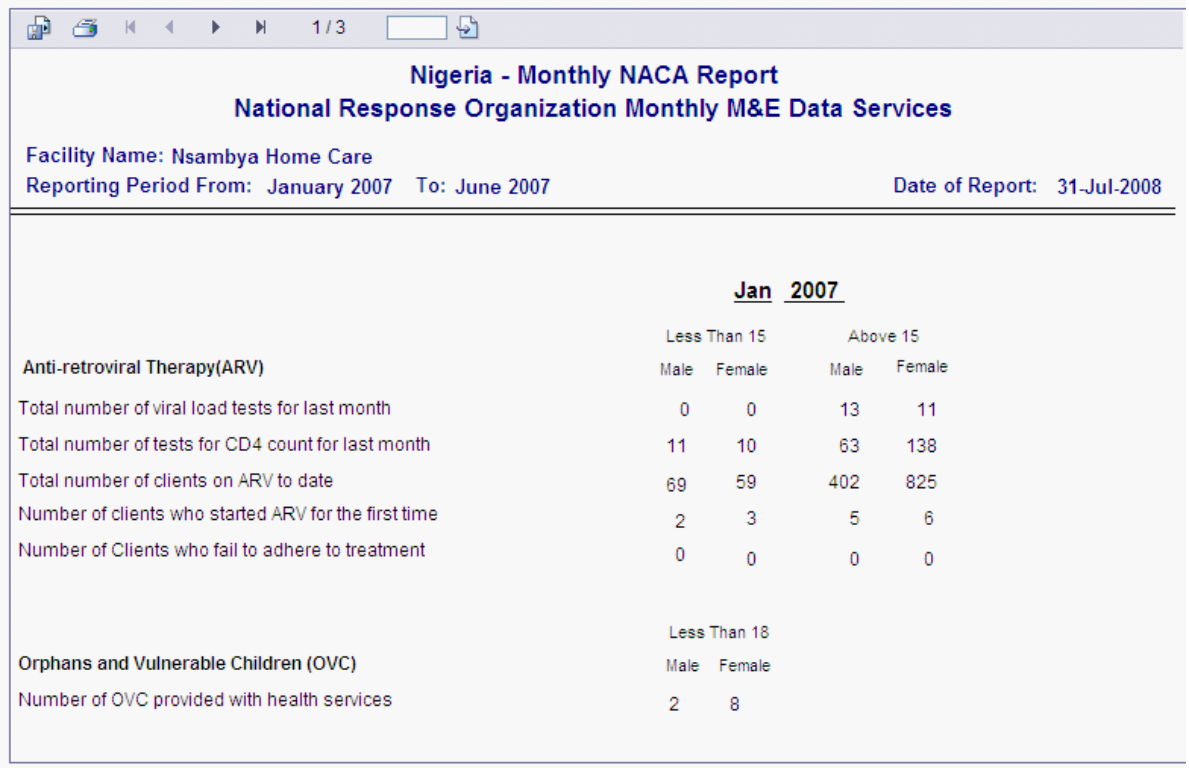

1 / 3

Nigeria - Monthly NACA Report
National Response Organization Monthly M&E Data Services

Facility Name: Nsambya Home Care
Reporting Period From: January 2007 To: June 2007 Date of Report: 31-Jul-2008

Jan 2007

Anti-retroviral Therapy(ARV)	Less Than 15 Male	Less Than 15 Female	Above 15 Male	Above 15 Female
Total number of viral load tests for last month	0	0	13	11
Total number of tests for CD4 count for last month	11	10	63	138
Total number of clients on ARV to date	69	59	402	825
Number of clients who started ARV for the first time	2	3	5	6
Number of Clients who fail to adhere to treatment	0	0	0	0

Orphans and Vulnerable Children (OVC)	Less Than 18 Male	Less Than 18 Female
Number of OVC provided with health services	2	8

7.5.3 Tanzania NACP

1. From the Facility level navigation, select Reports/Donor Reports

2. Select the Tanzania NACP Monthly/Quarterly Report and click the Submit button

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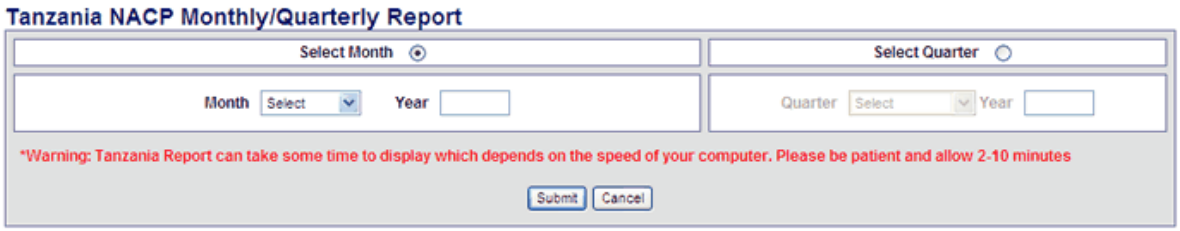
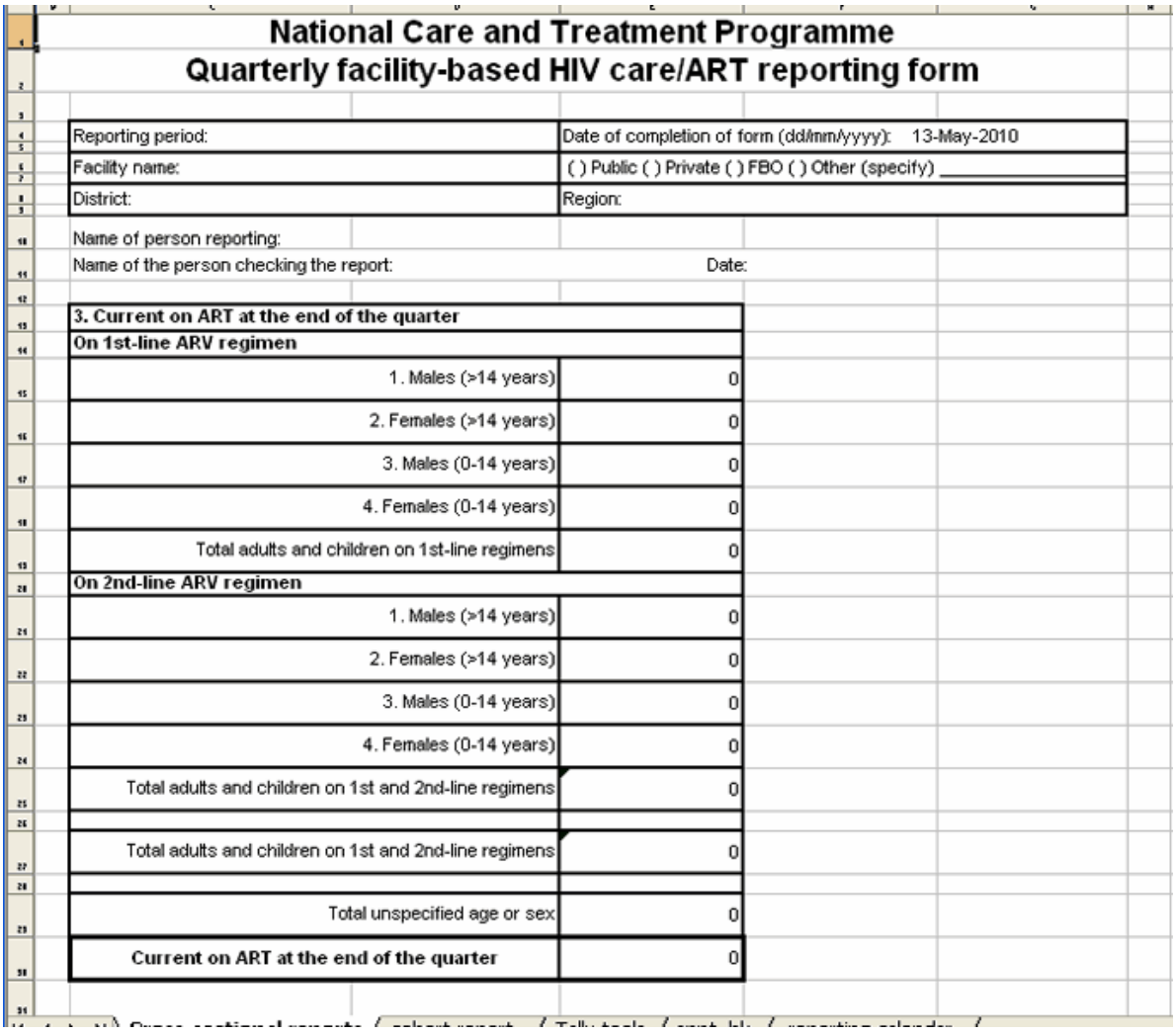


3. For the monthly report, select a month and year; for the quarterly report, select the quarter and year.
4. Click the Submit button.
5. Select Open or Save to view the Excel version of the report.

Here is an example of the quarterly report result.



National Care and Treatment Programme
Quarterly facility-based HIV care/ART reporting form

Reporting period:	Date of completion of form (dd/mm/yyyy): 13-May-2010
Facility name:	( ) Public ( ) Private ( ) FBO ( ) Other (specify) _____
District:	Region:

Name of person reporting:
Name of the person checking the report: Date:

3. Current on ART at the end of the quarter	
On 1st-line ARV regimen	
1. Males (>14 years)	0
2. Females (>14 years)	0
3. Males (0-14 years)	0
4. Females (0-14 years)	0
Total adults and children on 1st-line regimens	0
On 2nd-line ARV regimen	
1. Males (>14 years)	0
2. Females (>14 years)	0
3. Males (0-14 years)	0
4. Females (0-14 years)	0
Total adults and children on 1st and 2nd-line regimens	0
Total adults and children on 1st and 2nd-line regimens	0
Total unspecified age or sex	0
Current on ART at the end of the quarter	0

7.6 Donor Reports -PMTCT

PMTCT Donor reports available in IQCare

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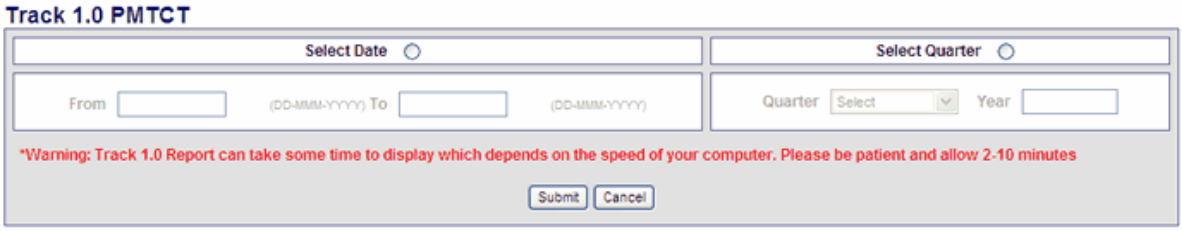
- Track 1.0 PMTCT
- Track 1.0 HIV Exposed Infants

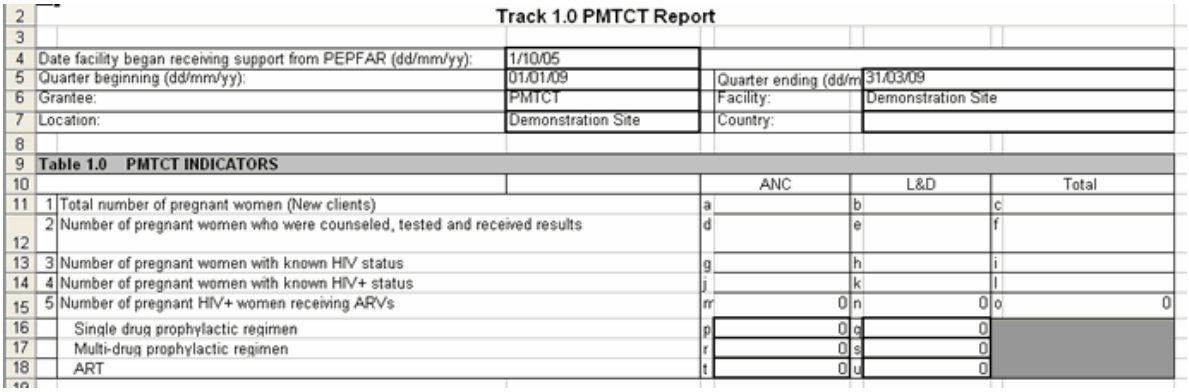
7.6.1 Track 1.0 PMTCT

1. Under Donor Reports, select the PMTCT tab, and then select the Track 1.0 PMTCT Report

2. Enter either a specific date range or enter the quarter for which you want the report to run and click the Submit button.



3. Select if you would like to Open or Save the file
4. The report displays using the CDC Track 1.0 PMTCT Excel template.
5. To return to IQCare, use the browser back button.



Track 1.0 PMTCT Report

4	Date facility began receiving support from PEPFAR (dd/mm/yy):	1/10/05					
5	Quarter beginning (dd/mm/yy):	01/01/09	Quarter ending (dd/m	31/03/09			
6	Grantee:	PMTCT	Facility:	Demonstration Site			
7	Location:	Demonstration Site	Country:				
8							
9	**Table 1.0 PMTCT INDICATORS**						
10			ANC		L&D		Total
11	1 Total number of pregnant women (New clients)		a		b		c
12	2 Number of pregnant women who were counseled, tested and received results		d		e		f
13	3 Number of pregnant women with known HIV status		g		h		i
14	4 Number of pregnant women with known HIV+ status		j		k		l
15	5 Number of pregnant HIV+ women receiving ARVs		m	0	n	0	o 0
16	Single drug prophylactic regimen		p	0	q	0	
17	Multi-drug prophylactic regimen		r	0	s	0	
18	ART		t	0	u	0	

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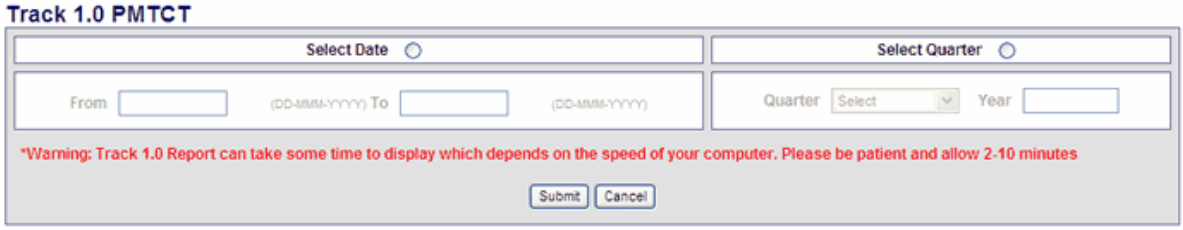
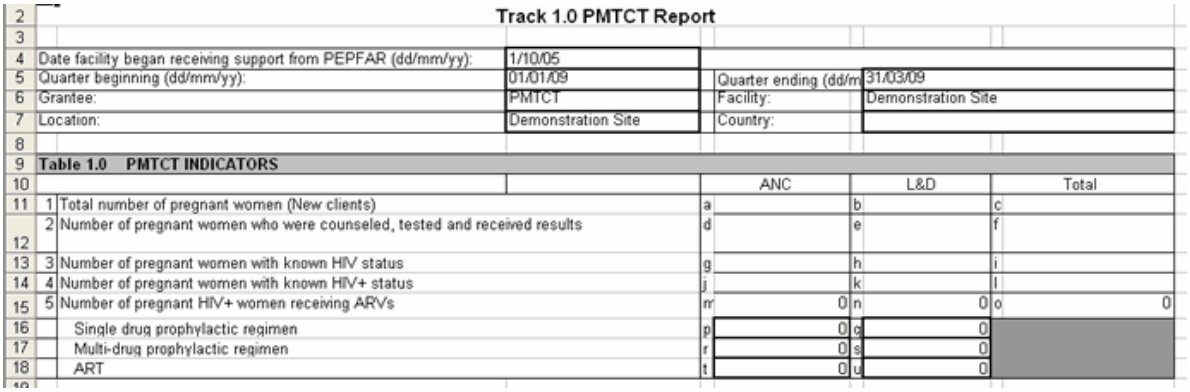
7.6.2 Track 1.0 Exposed Infants

1. Under Donor Reports, selecvt the PMTCT Tab and then select the Track 1.0 HIV Exposed Infants

2. Enter either a specific date range or enter the quarter for which you want the report to run and click the Submit button.



3. Select if you would like to Open or Save the file
4. The report displays using the CDC Track 1.0 PMTCT Excel template.
5. To return to IQCare, use the browser back button.



2		Track 1.0 PMTCT Report					
3							
4	Date facility began receiving support from PEPFAR (dd/mm/yy):	1/10/05					
5	Quarter beginning (dd/mm/yy):	01/01/09		Quarter ending (dd/m	31/03/09		
6	Grantee:	PMTCT		Facility:	Demonstration Site		
7	Location:	Demonstration Site		Country:			
8							
9	Table 1.0 PMTCT INDICATORS						
10				ANC		L&D	Total
11	1 Total number of pregnant women (New clients)		a		b		c
12	2 Number of pregnant women who were counseled, tested and received results		d		e		f
13	3 Number of pregnant women with known HIV status		g		h		i
14	4 Number of pregnant women with known HIV+ status		j		k		l
15	5 Number of pregnant HIV+ women receiving ARVs		m	0	n	0	o 0
16	Single drug prophylactic regimen		p	0	q	0	
17	Multi-drug prophylactic regimen		r	0	s	0	
18	ART		t	0	u	0	

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Part VII

8 Custom Reports

Custom reports allow you to investigate the data within and across forms. Listed below are the major features of the custom reports.

Managing Reports

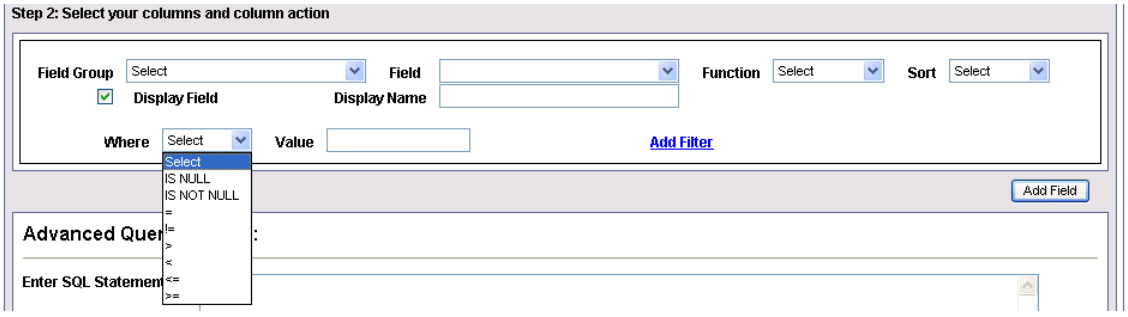
- Reports can be organized under user-defined categories
- They can be shared by exporting the report configuration to an export file which can then be imported by another instance of IQCare

Creating Reports

- Up to 12 columns can be displayed in a report
- There is an option to use a column for your report query, but not display the column in the actual report
- Field names are descriptive and should be intuitive
- Fields have been put into natural grouping for easy search or you can view the whole list of available fields.
- Each column used in the report can be filtered
- Each column has an editable title
- SQL is generated and visible as you add fields and filters to the report
- Advanced queries can be executed by changing the SQL in the Advanced SQL box

Field Filtering

- Fields attributes can be specified using - Null, Not Null, =, !=, <, > <=, =>
- Date fields span multiple years
- Results can be sorted in ascending/descending order, group by and count
- Up to 4 field filters available for each field using AND/OR
- There is an assumed AND between columns. If you would like to change that to an OR, you need to change the SQL in the Advanced SQL box
- For those fields that are select lists or multi-select lists in a clinical form when using the Equal To attribute, the associated list options are available for selection



Filter	Description	Example – Return Set Initial Set = {0, 1, 2, 3, 9, 25, 103}
IS NULL	There is an empty set. There are no values for the field.	No report results will be available because the set does not contain a null value.
IS NOT NULL	There is at least one value	{0, 1, 2, 3, 9, 25, 103}

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	for the field. The value can be zero.	
Equal to (=)	The filter value is exactly equal to one of the values in the set.	Suppose FilterValue = 3 ? result set will = 3 Suppose FilterValue = 4 ? result set will be empty as there is no field value equal to 4
Not Equal to (!=)	The filter value is not equal to any of the values in the set.	Suppose FilterValue = 2 ? result set will be {0, 1, 3, 9, 25, 103}
Greater than (>)	The filter value is strictly greater than one or more values in the set.	Suppose FilterValue > 3 ? result set will be {9, 25, 103}
Greater than or equal to (>=)	The filter value is greater than or equal to one or move values in the set.	Suppose FilterValue >= 3 ? result set will be {3, 9, 25, 103}
Less than (<)	The filter value is strictly less than one or more values in the set.	Suppose FilterValue < 3 ? result set will be {0, 1, 2}
Less than or equal to (<=)	The filter value is less than or equal to one or move values in the set.	Suppose FilterValue <= 3 ? result set will be {0, 1, 2, 3}

Running Reports

- Save and Run Report – saves the report parameters and runs the report. If the results are not correct, then you can click the Back button, change the report configuration and re-run the report.
- Export Report Parameters – creates an XML file so that the report configuration can be shared and re-run on another instance of IQCare (perhaps at a different clinic.)
- The SQL used to run the report is displayed at the top of the report
- The number of records in the report displays at the end of the report
- Reports can be printed
- Report can be saved to Excel

Editing Existing Reports

- Previously categorized and saved reports can be browsed and selected
- Previously save reports can be rename, re-categorize and have its description modified.
- Report parameters can be imported by browsing through and selecting exported XML file. The report parameters populate the report configuration screen at which point the report can be run or the parameters modified

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8.1 Patient and Treatment Location

There are two types of locations in IQCare:

1. The Patient Location is the location where the patient currently is getting treatment. A patient may start at one location and transfer to another location. The Patient Location is the location where the patient is right now.
   - The field for the Patient Location is found in the Patient Demographics field grouping.

2. The Treatment Location is where the patient received treatment. If a patient had labs done in one location and then transferred to another location and had another set of labs done, then you can find out which labs were done where.
   - The field for Treatment Location is found in the Visit field grouping.

For location definitions, see Facility Setup and the HIV Care Patient Number

8.2 Dynamic and Manual Entry Queries

An SQL query is the abbreviation for **S***tructured* ***Q****uery* ***L****anguage*, and is pronounced either see-kwell or as separate letters. SQL is a standardized query language for requesting information from a database. IQCare uses SQL to request data from the database in order to create Custom Reports. The Custom Reports feature of IQCare provides a tool for you to create SQL dynamically or "on the fly". By selecting the field groupings and fields along with the filters and functions, you direct IQCare to generate a complex SQL statement that pulls the correct data in the requested format into a report. This SQL can be seen at the bottom of the Custom Reports configuration page. Note that as you add fields and functions, the SQL builds and the statement gets larger.

▼ Dynamic Query Mode

In Dynamic Query mode the dynamic report configuration is enabled and the advanced query option where you can type SQL is disabled.

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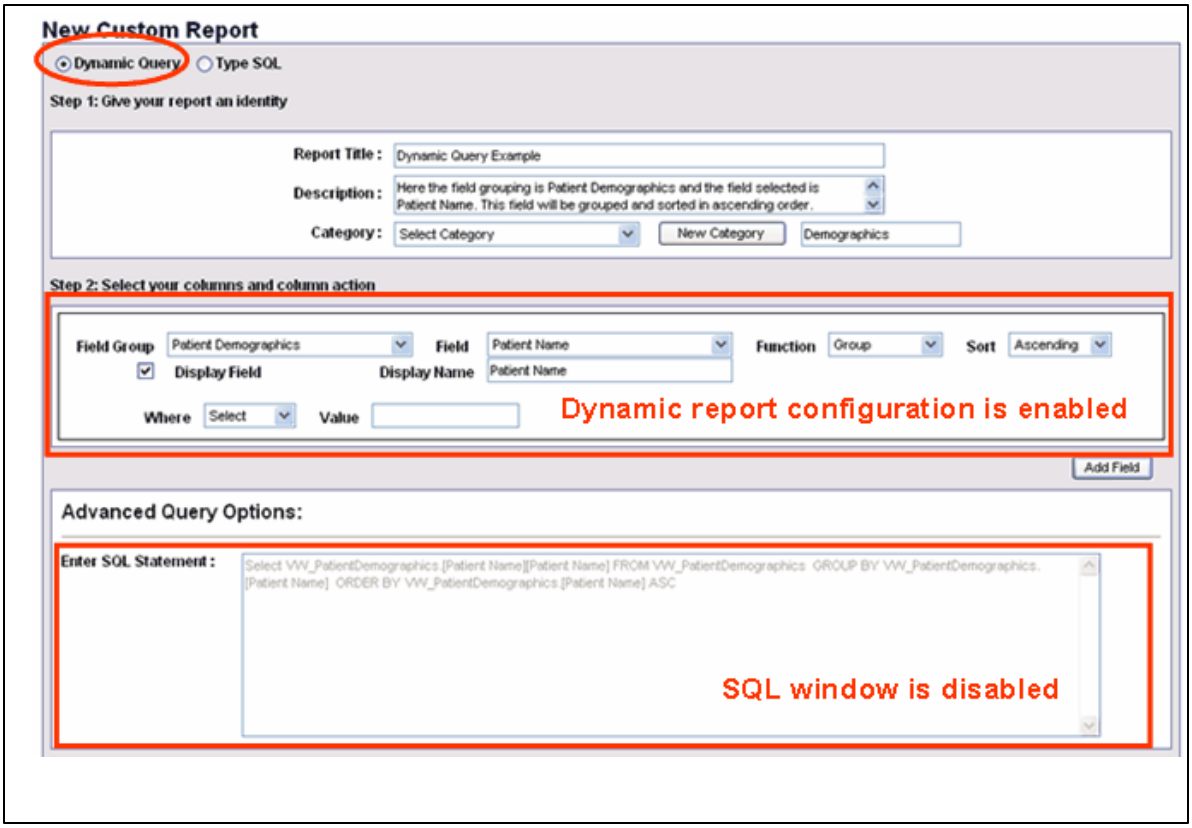

▼ Type SQL Mode

Sometimes, the reports you want to create can not be generated using the dynamic SQL feature in IQCare. In that case, you can use the Type SQL option and simply type or cut and paste the SQL statement you want run,into the box provided at the end of the Custom Report configuration page. In Type SQL mode the dynamic report configuration is disabled and the advanced query option where you can type SQL is enabled.

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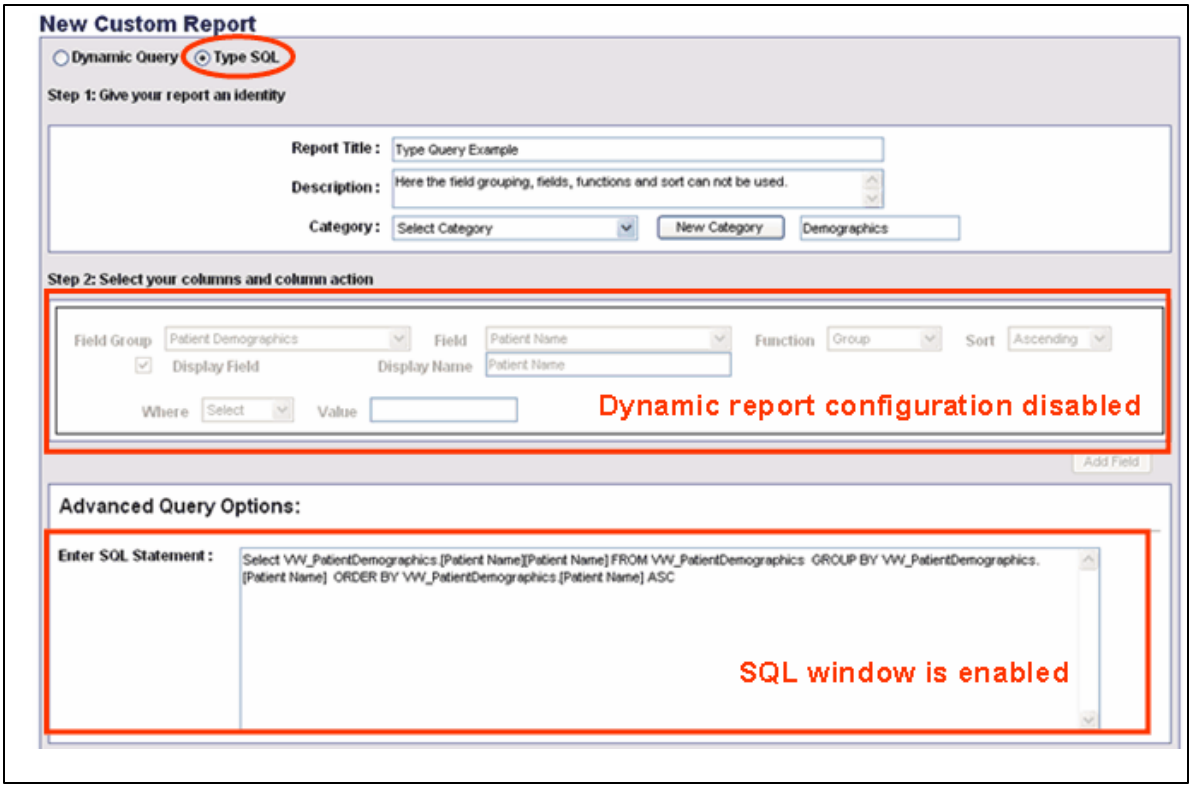
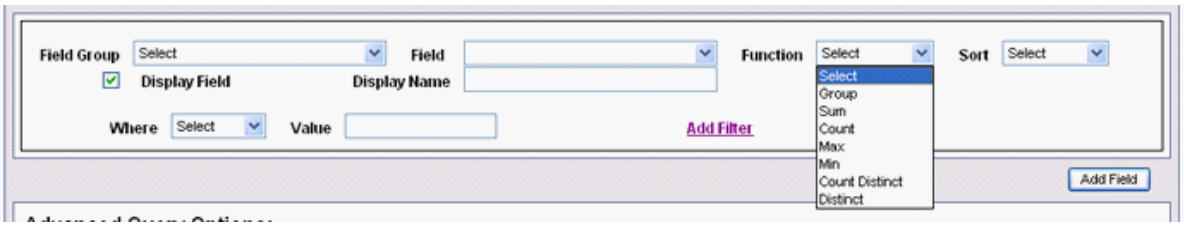


8.3 Custom Report Functions

IQCare custom reports have a number of functions that allow you to aggregate data. These are found under the “Function” select list. These functions tend to be used with more complex reports. Below is a very simple example that illustrates how to set up the custom report and the results for each function. Screen shots of how this example is done in IQCare are provided in the IQCare Help/ Custom Report Functions. This link can be found in the left hand navigation.



Report Functions Example
In this example there are two patients, Jones and Smith. Jones has been dispensed Lamivudine and Nevirapine on three different dates. Smith has been dispensed only Lamivudine on two dates.

Last Name	Dispensed by Date	Generic Name	Quantity Dispensed
Jones	10-Sep-2006	Lamivudine Nevirapine	28 28

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Jones	7-Oct 2006	Lamivudine Nevirapine	56 56
Jones	15-Dec- 2006	Lamivudine Nevirapine	28 28
Smith	6-Aug-2006	Lamivudine	28
Smith	3-Sep-2006	Lamivudine	28

Using the data in this example, each function will be used to show how it can be used. Note that this is only one example. There are many ways to use these functions. You will need to do some trial and error to be able to produce the reports you need.

Note: when you use a function of one of the fields, you must place all of the other with the Group function.

Function	Description	Example – Field Set Up	Example – Return Set
Group	Groups like FieldValues	Last Name – Group Dispensed by Date – Group Generic Drug Name – Group Dispensed Quantity – Group	The result set will grouped by Last Name The data is grouped by the field found in the first column select. For example, if you changed the order and put Generic Name first, the report would be grouped by the generic name. Smith – Lamivudine – 28 – 06-Aug-2006 Smith – Lamivudine – 28 – 03-Sep-2006 Jones – Lamivudine – 28 – 10-Sep-2006 Jones – Nevirapine – 28 – 10-Sep-2006 Jones – Lamivudine – 56 – 07-Oct-2006 Jones – Nevirapine – 56 – 07-Oct-2006 Jones – Lamivudine – 28 – 15-Dec-2006 Jones – Nevirapine – 28 – 15-Dec-2006
Sum	Sums the FieldValues	Last Name – Group Generic Drug Name – Group Dispensed Quantity – Sum	The result set will add up all of the quality dispensed values for each generic drug and each patient. Jones – Lamivudine – 112 Jones – Nevirapine – 112 Smith – Lamivudine – 56 Note that the Dispensed by Date is

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			not included in this query. Because each Dispensed by Date is unique, the data can not be summed up. If there was more than one Lamivudine dispensed on a Dispensed by Date, each of those would be added up. But IQCare doesn't allow this situation.
Count	Counts all of the instances of a FieldValue	Last Name – Group Generic Drug Name – Count Dispensed Quantity – Group	The result set will count all of the instances of Lamivudine and Nevirapine with each different dispensed quantity, 28 and 56. In our example, for patient Jones, there are 4 instances of Lamivudine with the quantity dispensed of 28 days. Jones – 4 – 28 Jones – 2 – 56 Smith – 2 – 28
Max	Selects the largest or latest FieldValue	Last Name – Group Dispensed by Date – Max Generic Name – Group	For each Last Name and Generic Drug combination, the largest or latest date is selected. Jones – 15 –Dec-2006 – Lamivudine Jones – 15 –Dec-2006 – Nevirapine Smith – 3 Sep-2006 -- Lamivudine
Min	Selects the smallest or earliest FieldValue	Last Name – Group Dispensed by Date – Min Generic Drug Name – Group	For each Last Name and Generic Drug combination, the smallest or earliest date is selected. Jones – 10-Sep-2006 – Lamivudine Jones – 10-Sep-2006 – Nevirapine Smith – 6-Aug-2006 – Lamivudine
Count Distinct	Counts the number of unique instances of a FieldValue	Last Name – Group Generic Drug Name – Count Distinct Dispensed Quantity – Group	Result set will count all of the instances of each Generic Drug Name
Distinct	If there are duplicates on the set, only the first instance is displayed	Last Name – (no Group) Generic Drug Name –Distinct Dispensed Quantity (no Group)	For each Last name, only one instance of the Generic Drug Name and quantity combination will display. Jones – Lamivudine – 28 Jones – Nevirapine – 28 Jones – Lamivudine – 56 Smith – Lamivudine – 28

8.4 Create a Custom Report

1. From the Facility level navigation, select Reports/Custom Reports

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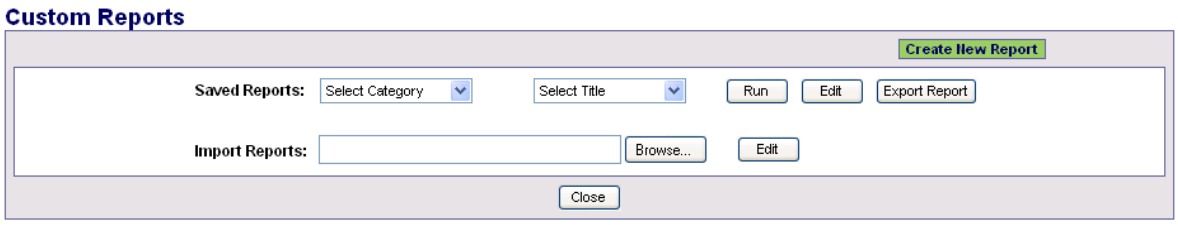
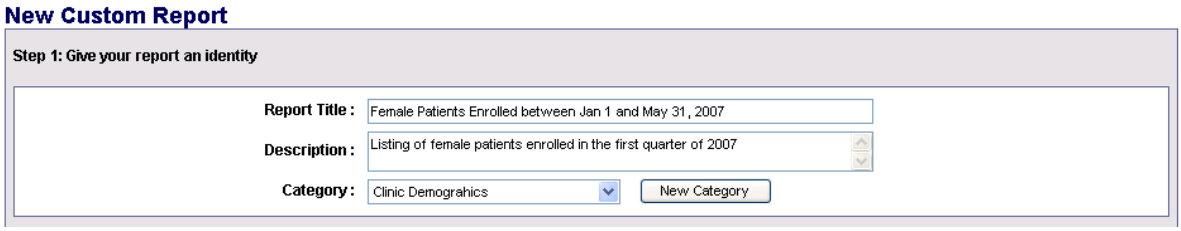
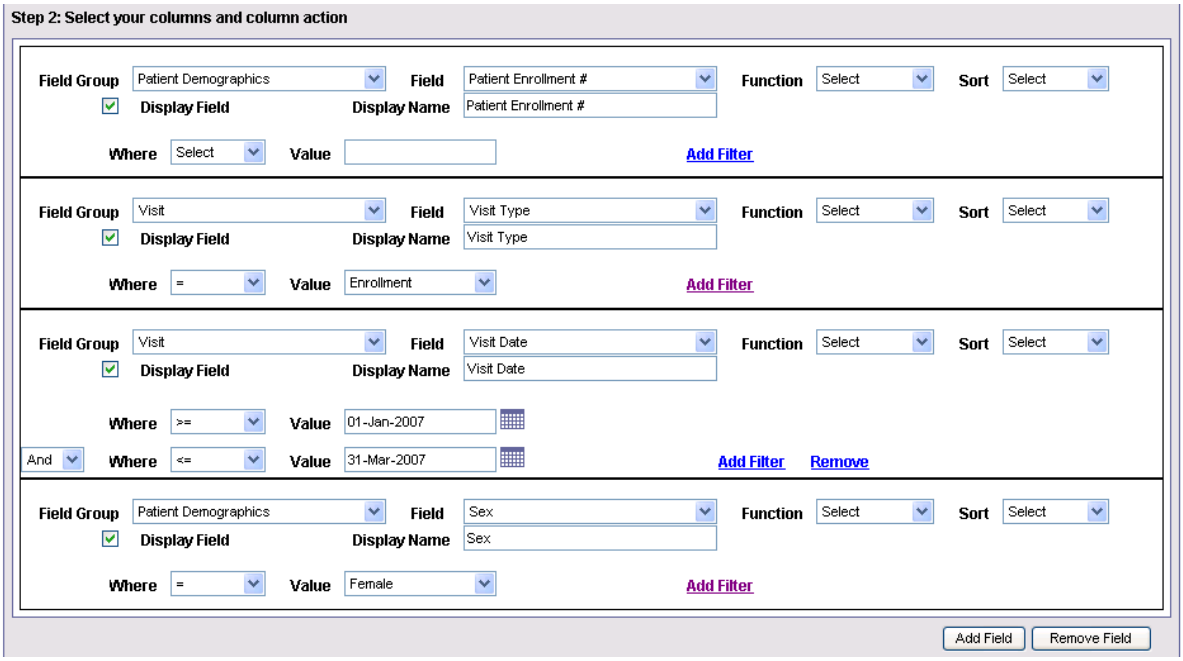


2. Click on the Create New Report button
3. Enter the report title, description and category. If the category does not exist, then enter a new category.


New Custom Report
Step 1: Give your report an identity
Report Title :
Female Patients Enrolled between Jan 1 and May 31, 2007
Description :
Listing of female patients enrolled in the first quarter of 2007
Category :
Clinic Demograhics
New Category

4. For each column in the report:
   a. Uncheck the column display if the column should not be displayed
   b. Select the Field category
   c. Select the field
   d. Select a sort, grouping (optional)
   e. Select one or more filters (optional). To add additional filters, click the Add Filter link. To remove a filter, click the remove filter link



5. For another column, click the Add column; repeat until you have all of the columns and filters that you want
6. To add special SQL processing, change the code found in the SQL Statement box.

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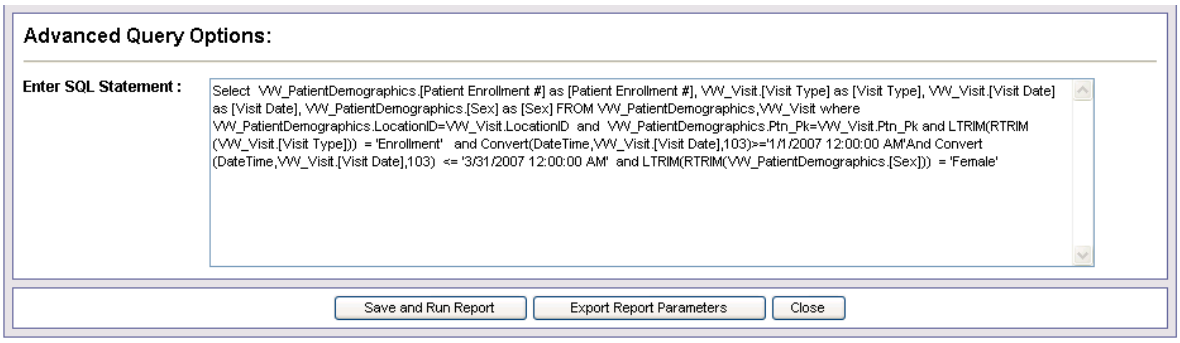
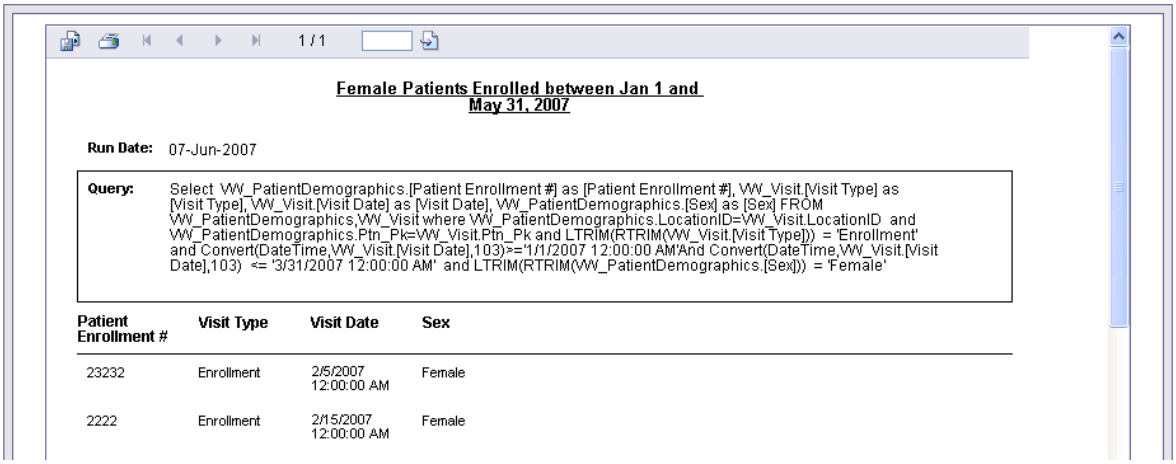

Advanced Query Options:
Enter SQL Statement :
Select VW_PatientDemographics.[Patient Enrollment #] as [Patient Enrollment #], VW_Visit.[Visit Type] as [Visit Type], VW_Visit.[Visit Date] as [Visit Date], VW_PatientDemographics.[Sex] as [Sex] FROM VW_PatientDemographics,VW_Visit where VW_PatientDemographics.LocationID=VW_Visit.LocationID and VW_PatientDemographics.Ptn_Pk=VW_Visit.Ptn_Pk and LTRIM(RTRIM (VW_Visit.[Visit Type])) = 'Enrollment' and Convert(DateTime,VW_Visit.[Visit Date],103)>='1/1/2007 12:00:00 AM'And Convert (DateTime,VW_Visit.[Visit Date],103) <= '3/31/2007 12:00:00 AM' and LTRIM(RTRIM(VW_PatientDemographics.[Sex])) = 'Female'
Save and Run Report
Export Report Parameters
Close

7. Click Save and Run Report
8. View the results

Custom Report


1 / 1
Female Patients Enrolled between Jan 1 and May 31, 2007
Run Date: 07-Jun-2007
Query: Select VW_PatientDemographics.[Patient Enrollment #] as [Patient Enrollment #], VW_Visit.[Visit Type] as [Visit Type], VW_Visit.[Visit Date] as [Visit Date], VW_PatientDemographics.[Sex] as [Sex] FROM VW_PatientDemographics,VW_Visit where VW_PatientDemographics.LocationID=VW_Visit.LocationID and VW_PatientDemographics.Ptn_Pk=VW_Visit.Ptn_Pk and LTRIM(RTRIM(VW_Visit.[Visit Type])) = 'Enrollment' and Convert(DateTime,VW_Visit.[Visit Date],103)>='1/1/2007 12:00:00 AM'And Convert(DateTime,VW_Visit.[Visit Date],103) <= '3/31/2007 12:00:00 AM' and LTRIM(RTRIM(VW_PatientDemographics.[Sex])) = 'Female'
Patient Enrollment # | Visit Type | Visit Date | Sex
23232 | Enrollment | 2/5/2007 12:00:00 AM | Female
2222 | Enrollment | 2/15/2007 12:00:00 AM | Female

9. If the report is not configured correctly, then click the Back button to view your column and filter selections and make changes; Click Save and Run Report again.
10. To print the report, click the printer icon; to save the data to Excel, click the spreadsheet icon.

8.5 Report on Custom Fields

Reports can easily be created for all of the data gathered in custom fields. The steps to create a report are same as reporting on data that are captured on the clinical forms. Custom fields are separated by the form it appears on. For example if you collect data for the question “How many sexual partners since the last visit?” on the enrollment and follow up forms, you will need to report on data gathered in all three forms, separately. The example below illustrates the steps.

1. Configure custom fields

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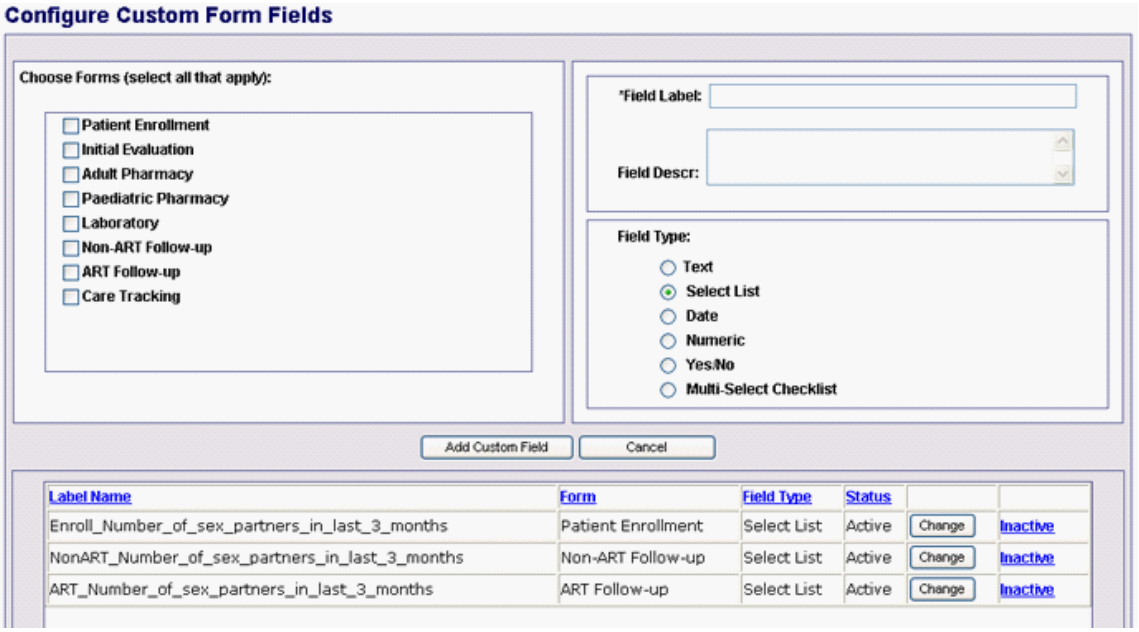
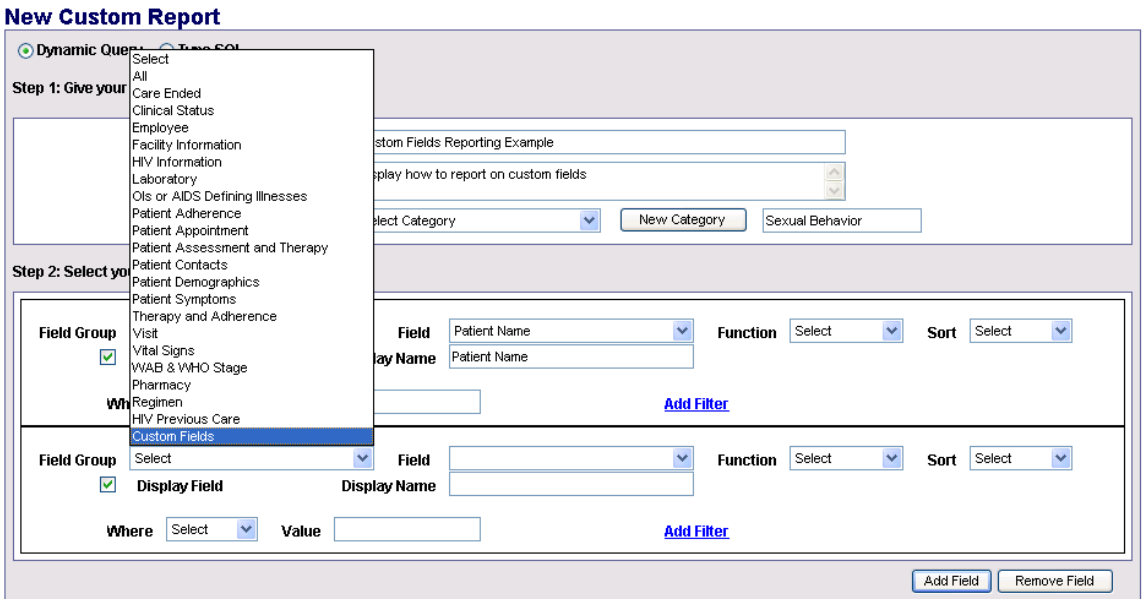


2. Create a custom report, selecting the Field Grouping - Custom Fields



3. Select the custom field you want to report on. Note that if you want to report on the custom field, but data gathered on different forms, you must select the custom field for each form.

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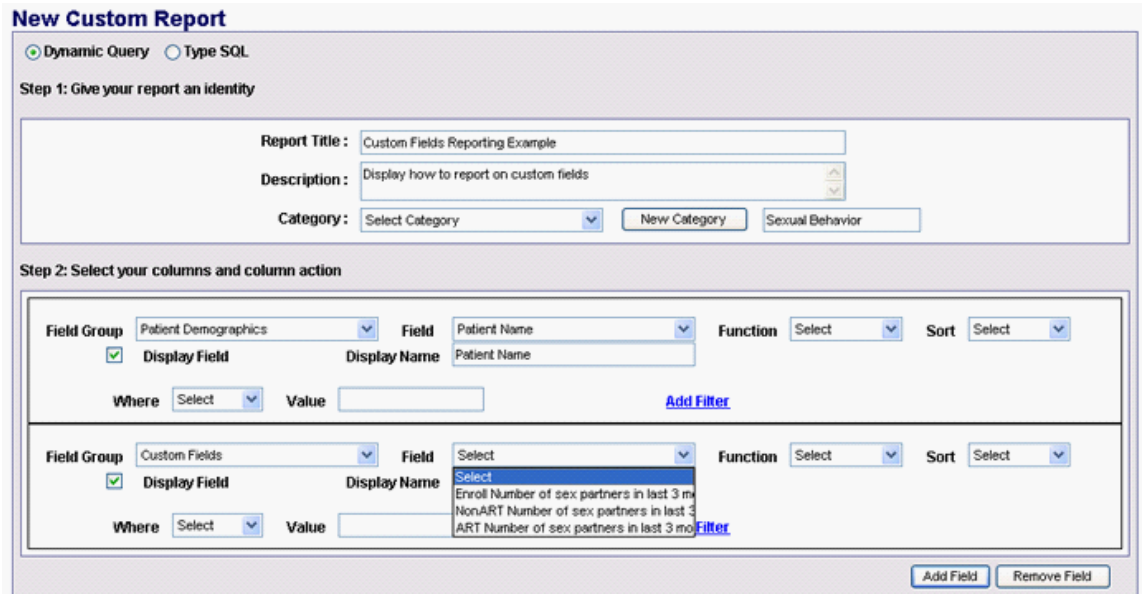
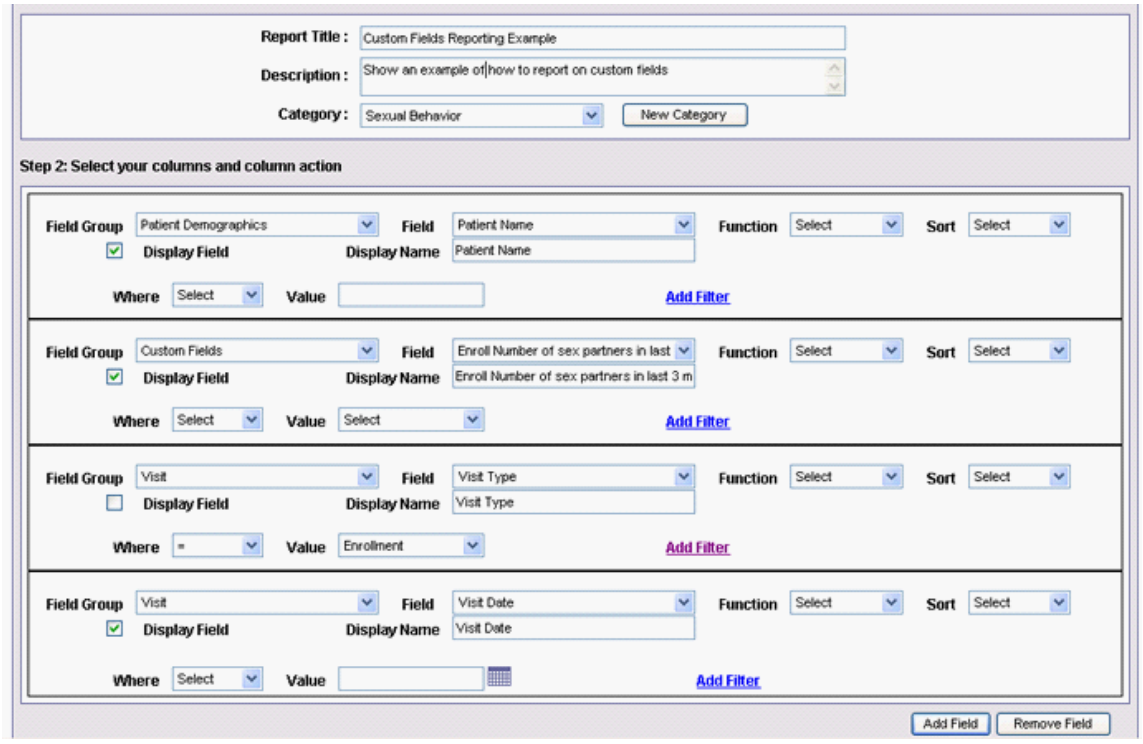


4. Select any other fields you want in your report



5. Run the report

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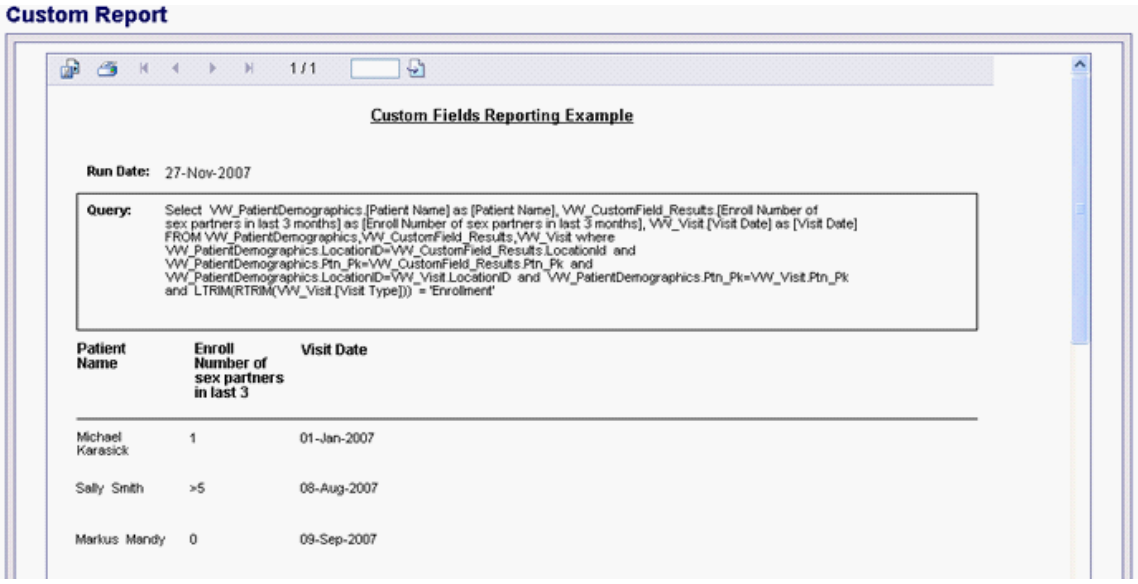
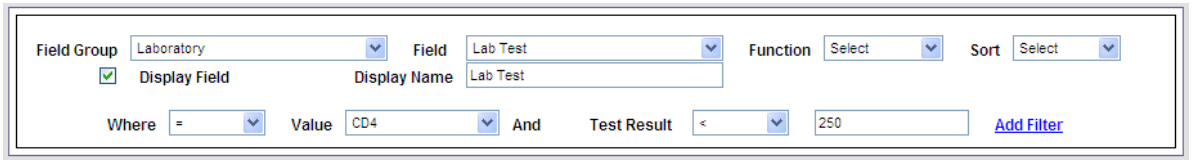

Custom Report
1 / 1
Custom Fields Reporting Example
Run Date: 27-Nov-2007
Query: Select VW_PatientDemographics.[Patient Name] as [Patient Name], VW_CustomField_Results.[Enroll Number of sex partners in last 3 months] as [Enroll Number of sex partners in last 3 months], VW_Visit.[Visit Date] as [Visit Date] FROM VW_PatientDemographics,VW_CustomField_Results,VW_Visit where VW_PatientDemographics.LocationID=VW_CustomField_Results.LocationId and VW_PatientDemographics.Ptn_Pk=VW_CustomField_Results.Ptn_Pk and VW_PatientDemographics.LocationID=VW_Visit.LocationID and VW_PatientDemographics.Ptn_Pk=VW_Visit.Ptn_Pk and LTRIM(RTRIM(VW_Visit.[Visit Type])) = 'Enrollment'
Patient Name
Enroll Number of sex partners in last 3
Visit Date
Michael Karasick 1 01-Jan-2007
Sally Smith >5 08-Aug-2007
Markus Mandy 0 09-Sep-2007

8.6 Report on Laboratory Results

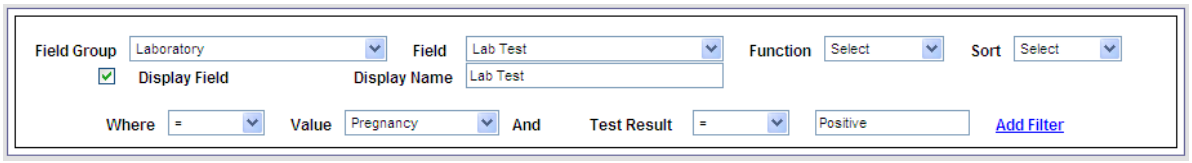
There is a slightly different filtering set up for querying on laboratory results. Each lab test can be further filtered to query for a value or range of values.

To create a laboratory report for numeric valued lab tests



1. Select the Laboratory field group
2. Select Lab test
3. Select Where = the lab test you want to query
4. Test Result numeric operator such as < or IS NOT NULL
5. Test Result field enter a numeric value or leave empty if you have selected IS NOT NULL

To create a laboratory report for numeric valued lab tests



1. Select the Laboratory field group
2. Select Lab test
3. Select Where = the lab test you want to query
4. Test Result text operator = or IS NOT NULL

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5. Test Result field enter a text value or leave empty if you have selected IS NOT NULL; note the list of text values below.

Lab Test	Result Text
HIV Serology	Positive, Negative
Serum Crypto Ag	Positive, Negative
Sputum AFB1	Positive, Negative
Sputum AFB2	Positive, Negative
Sputum AFB3	Positive, Negative
Sputum Gram Stain	Use “Is Not Null” to get free text results
Stool O/P	Positive, Negative
Urine Microscopic Blood	0-2, 3-5, 6-10, 11-25, TNTC
Urine Microscopic WBC	0-2, 3-5, 6-10, 11-25, TNTC
Urine Microscopic Bacteria	0-2, 3-5, 6-10, 11-25, TNTC
Urine Microscopic Casts	Hyaline, Granular, RBC, WBC, Waxy
CSF Crypto	Positive, Negative
CSF India Ink	Positive, Negative
CSF Gram Stain	Positive, Negative
CSF Culture	Use Is Not Null to text results
X Ray Status	Abnormal, Normal
Pregnancy	Positive, Negative
Test with text handled with numbers	
Store Plasma	Stored = 1.0
Malarial Parasite	1.0, 0.0

8.7 Export a Report

There are two locations where you can export a report. The first is in the custom reports entry page. If there is an existing report that you want to export, you can so from this page. The second location is at the bottom of the report configuration page. There you have the option to save and run or export report parameter. It is recommended that you first run a report, view the results to verify that the columns and results are correct. Once satisfied, click the Back button to return to the report configuration page, and then click Export Report Parameters.

Follow Steps 1 though 5 of Create a Custom Report then...

1. Click the Export Reports Parameters button found at the bottom of the custom reports configuration screen
2. IQCare displays a window asking if you would like to open or save the file; click Save

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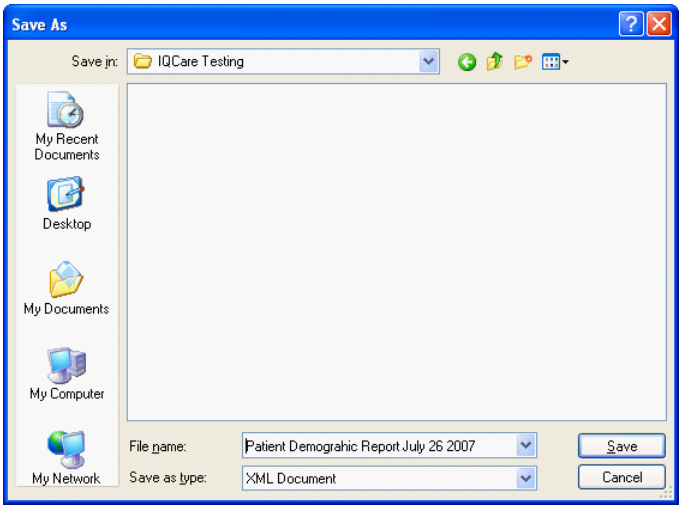
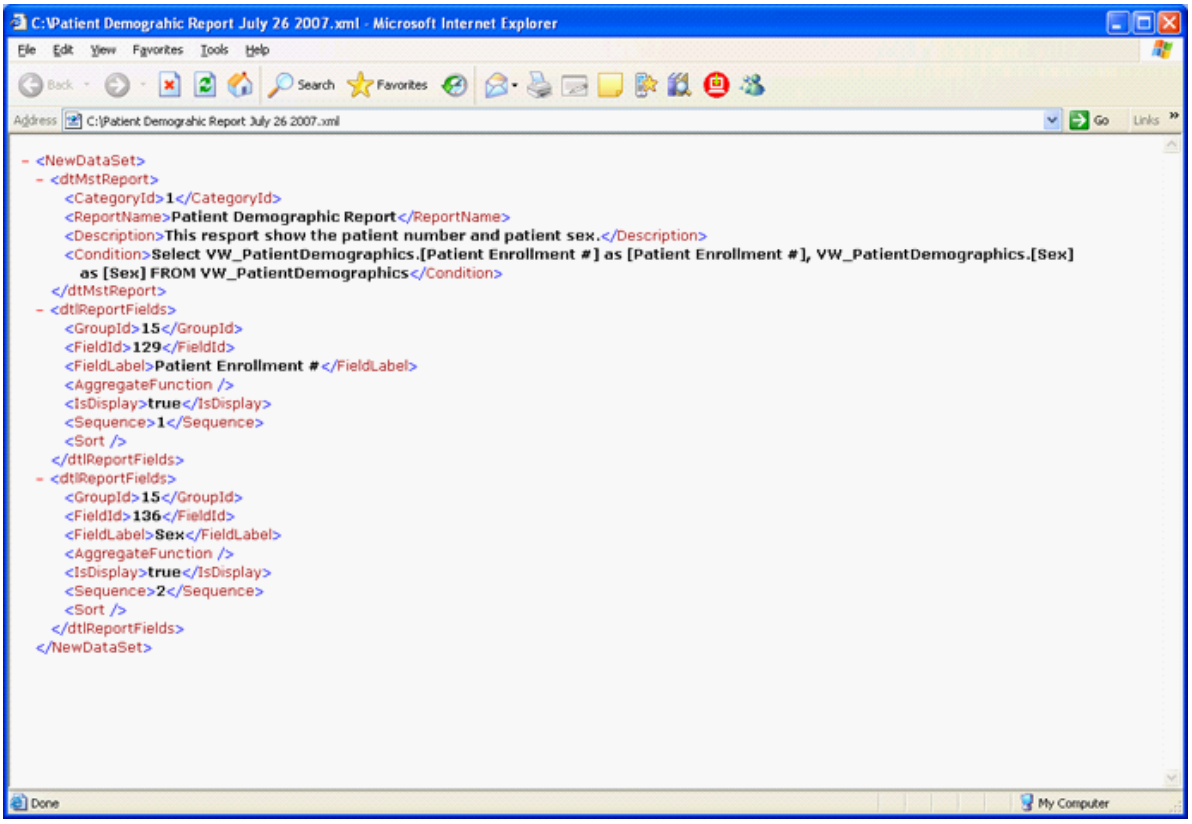
3. Browse to find the location on your local or LAN drive to save the XML file, and give the file an appropriate name



4. Click Save to save the file



This is what the XML files looks like. It contains all of the configuration parameters so that you can share the report configuration with others.

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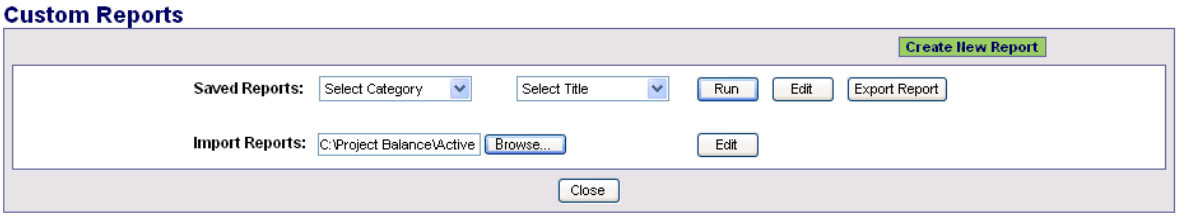
8.8 Import and Run a Report

1. From the Facility level navigation, select Reports/Custom Reports
2. At the entry page, click the Browse button to find the XML file with the report parameters you would like to upload.

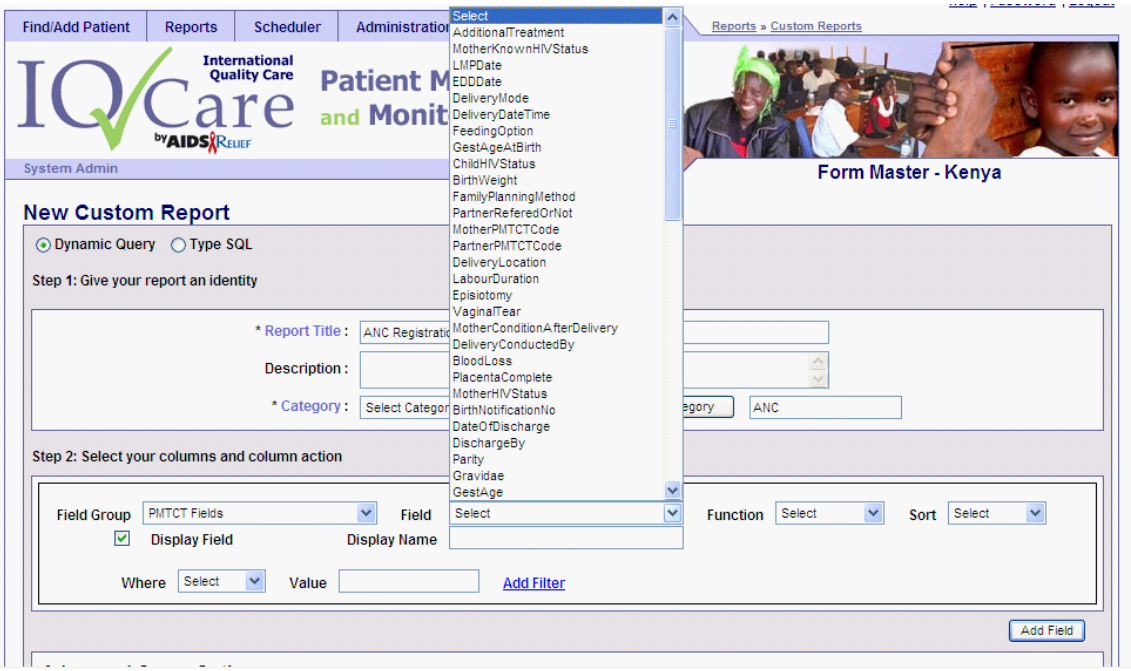


3. Click Edit to display the parameters in the custom report configuration page
4. Make any changes you would like
5. Click Save and Run Report

8.9 Custom Reports with PMTCT Fields

Custom Reports for the PMTCT program work in the same way as with the ART program. The fields from the PMTCT enrollment form, pharmacy, laboratory and care tracking forms are available in the same locations as the ART program. The pre-defined fields and custom fields defined in Form Builder will be part of the PMTCT Fields group. Custom Fields created for the static forms are found under Custom Fields group.

As before, PMTCT fields can be combined with other static fields to generate a custom query.

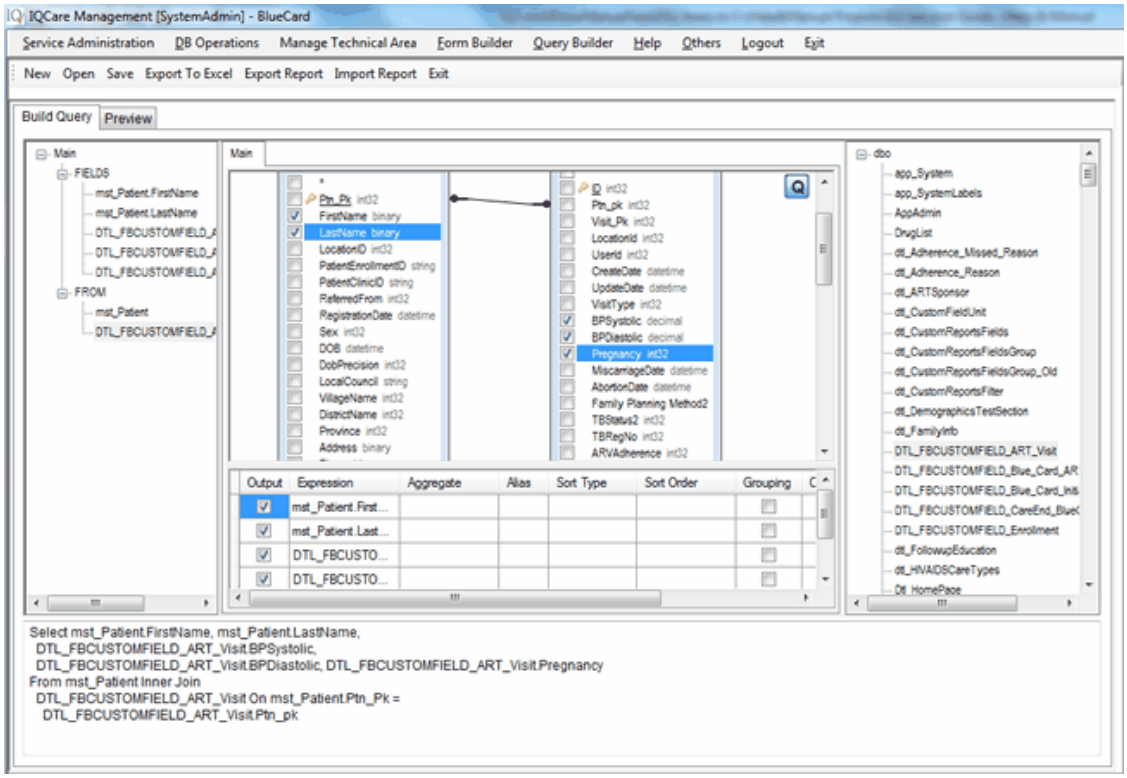


Part

9 Query Builder Reports

IQCare provides a way to pre-define reports in IQCare Management and run the reports in IQCare. Queries saved using the Query Builder are accessible under the Report navigation.

- Create a query in IQCare Management
  1. In IQCare Management, create and preview your report.
  2. Save the report under a category and name the report. In this example, the category is Patient Visit Reports and the report name is Vital Signs.



  3. Save the report under a category and name the report. In this example, the category is Patient Visit Reports and the report name is Vital Signs.

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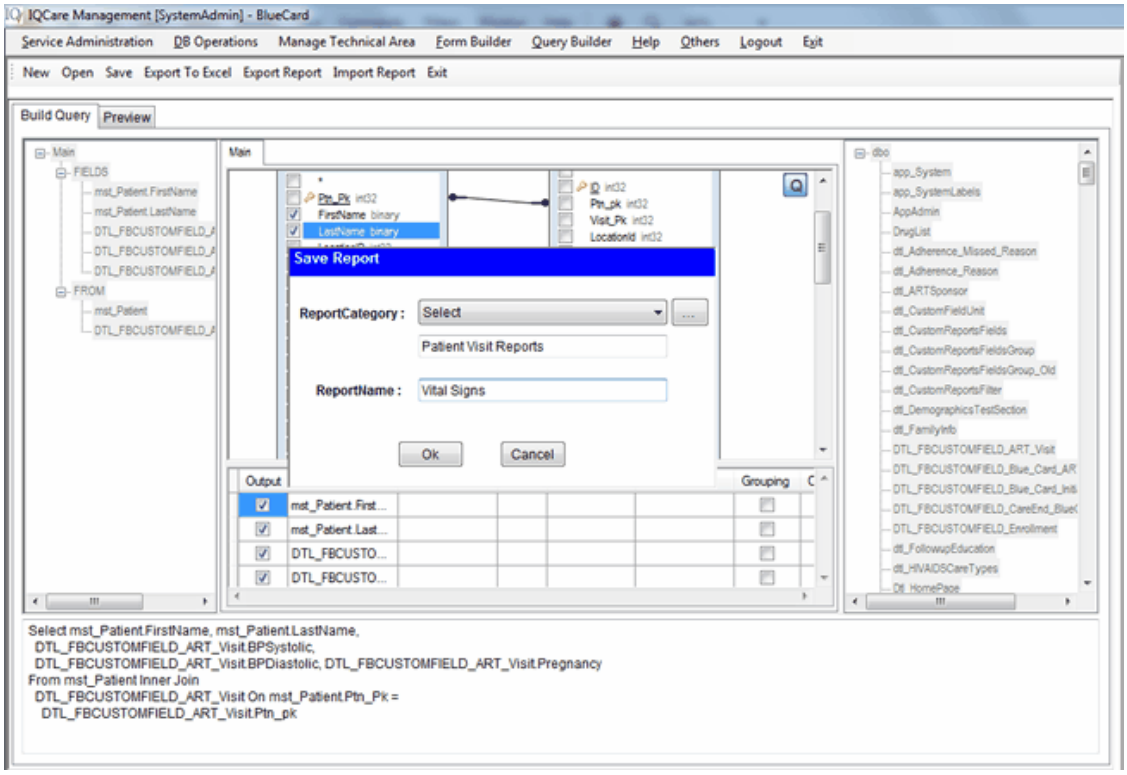
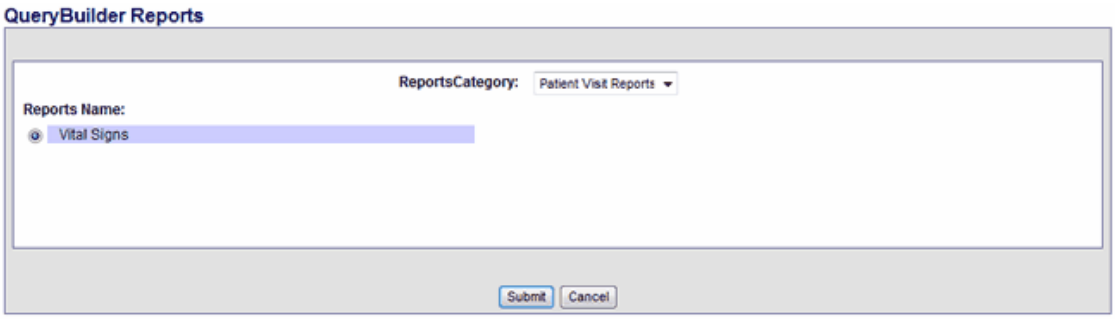


- To run a report in IQCare
  1. Select the report category
  2. Then select the report name



  3. Click Submit to run the report
  4. IQCare will open Excel and the report results will display.

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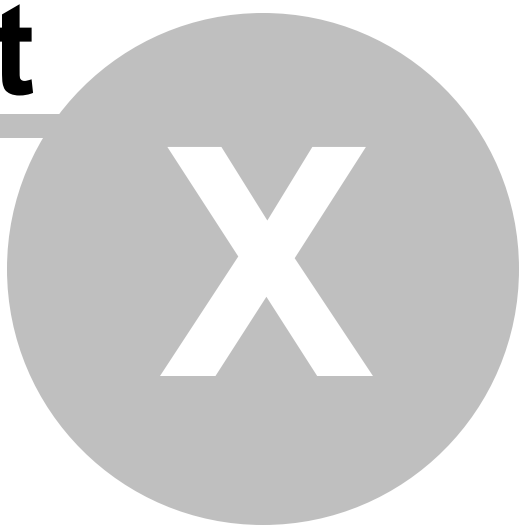
Part



10 Clinical Forms

In IQCare there are two types of clinical forms:

1. HIV Static forms - these are pre-defined forms that cannot be modified by the User. Custom fields can be added to the bottom of the forms.
2. Dynamic form builder forms - these are defined and updated by the User. They are completely flexible as per your design.

IQCare allows you to mix and match static and dynamic forms so that you can configure a form set that exactly matches you organization's needs. The tool is extremely flexible. We highly recommend that before you start building forms, you follow our recommended preparation steps.

10.1 HIV Care Form Set

The AIDSRelief form set was developed in partnership with the Institute of Human Virology, University of Maryland. These forms have been used since the inception of the program for Kenya, Uganda and Nigeria.

These longitudinal forms capture all of the data specified in the 3ILPMS for HIV Care field requirements plus some.

Under the Create New Forms Link:

- HIV Care Enrollment
- Initial Evaluation
- ART Follow up
- Non-ART Follow up
- Adult Pharmacy
- Paediatric Pharmacy
- Laboratory
- Care Tracking
- Home Visit

Under the Additional Forms Link:

- Family Information

For the data dictionaries of these forms, please see HIV Care Forms Data Dictionary

10.1.1 Adding Dynamic Forms to the HIV Care Form Set

IQCare provides the ability for you to create custom forms using the IQCare Form Builder and adding to the available HIV Static forms that are already provided. By creating forms associated with the HIV Care Static forms technical area, these new forms will be available for use in IQCare under the Create New Form list in the patient level navigation.

Add a dynamic form to the HIV Care Static form set

1. Create a dynamic form in IQCare form builder. Be sure to assign the form to the HIV Care Static Form technical area before you save the form.
2. Publish the form (see Publish Forms for more information)
3. Login to IQCare and find an existing or create a new patient
4. Select the HIV Care Static Form technical area
5.

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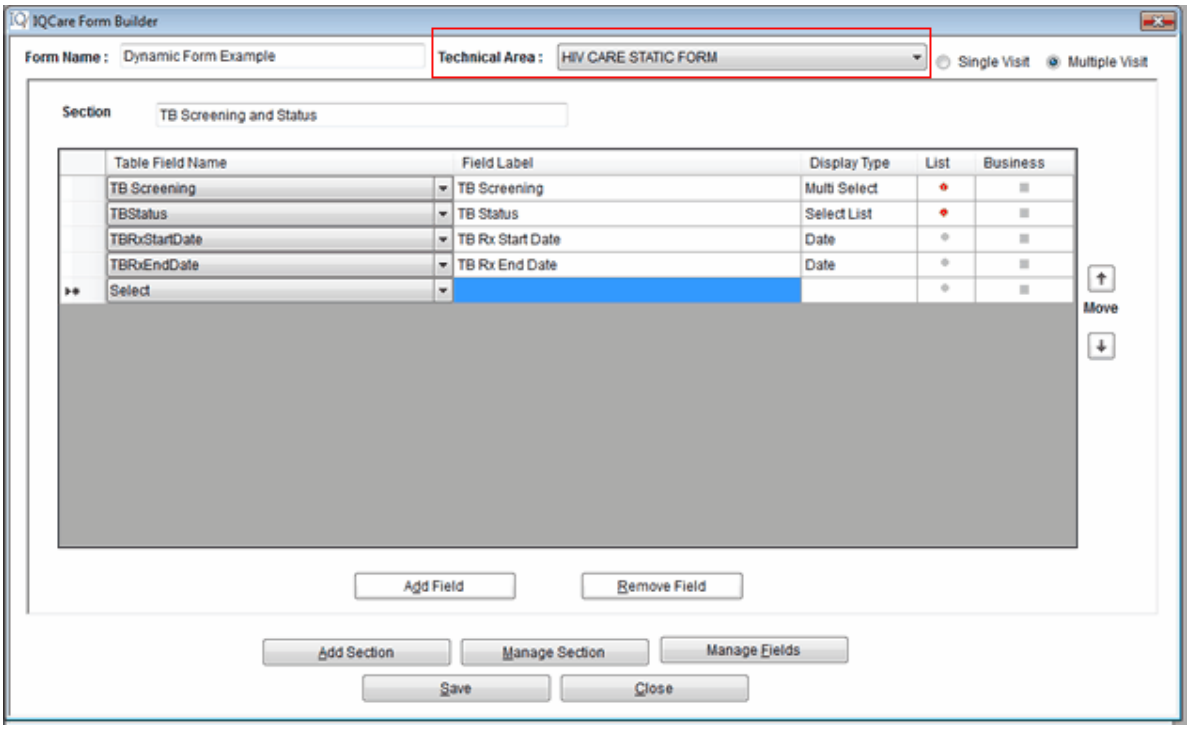

2. P

10.1.2 TB Indicators

TB indicators gathered in IQCare

HIV Care Static From Set

- TB Screening - in the ART and Non-ART follow up forms. This is a customizable select list called TB Screening.
- TB Illnesses - in the Initial Evaluation, ART and Non-ART follow up forms
- TB Regimens prescribed - in the Adult and Pediatric pharmacy forms
- TB Regimen select list configuration - in the TB Regimens custom list

10.1.3 Enrollment

Fill in an Enrollment Form

1. From the Facility level navigation, click on Find/Add patient
2. Verify that the patient does not exist by entering first and last name and any other information you know about the patient. Click the Find button.
3. If the patient does not exist, click the Add button
4. Fill-in the form, making sure you fill out the required fields
5. Click Save
6. IQCare displays a message alerting you of any required fields not filled in
7. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update an Enrollment Form

1. To access an previously filled in enrollment form, either

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a. Click on View Existing Forms and find the Enrollment form OR
b. Click on the Enrollment form link found in the Patient level navigation
2. Update the form
3. Click Submit

10.1.4 Family Information

Fill in a Family Information Form

1. From the Patient Home Page, click on the Family Information link
2. If the family member is an existing patient and is registered at this or its satellite clinics, select "Yes".
    a. Click the Find Patient button
    b. Using the Find Patient form, enter information about the family member and click Find
    c. Select the family member from the list of patients. The information about the family member will fill into the fields in the Family Information form.
    d. Select the Relationship type. If the Relationship Type is Partner/Spouse or Child, you may enter the Birth/Marriage Date associated with the relationship type.
    e. Click Add Member to save. The family member information displays in the grid below.
3. If the family member is not registered at this or its satellite clinics select "No".
    f. Fill all of the fields provided. All fields except for the Birth/Marriage Date are required fields.
    g. Click Add Member to save. The family member information displays in the grid below.
4. Click Save

Update a Family Information Form

1. From the Patient Home Page, click on the Family Information link
2. To update an existing family member, click on the row of the family member you want to update. The family member's information will display.
3. If the family member is already registered at the clinic, his/her information will reflect what is in the IQCare database. To update this information you must go into the family member's records.
4. If the family member is not register at the clinic, then update the fields directly.
5. To delete a family member, click on the trash can icon at the right side on each row.
6. Click Save

10.1.5 Initial Evaluation

Fill in a New Initial Evaluation Form

1. From the Patient Home Page, click on the Create New Form link and select the Initial Evaluation form.
2. Fill in the form, making sure you fill in the required fields. Note that some of the fields will be auto populated.
3. Click Save
4. IQCare displays a message alerting you of any required fields not filled in
5. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update an Initial Evaluation Form

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1. To access a previously filled in Initial Evaluation form click on View Existing Forms and find the Initial Evaluation form you want to update and click the link
2. Update the form
3. Click Save

** For the Paperless Facility the Initial Evaluation form can be filled out in two steps. The nurse can fill out and save the vitals at triage, before the clinician sees the patient. The clinician can fill out the remainder of the form.

View the Initial Evaluation Form

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Initial Evaluation Form

Patient Name: Boxter, Karen IQ Number: IQ-000000KB198001017542

Unique ID : 100-100-100-8945 Patient Clinic # : 5612-12

*Visit Date: (DD-MMM-YYYY) Date of HIV Diagnosis: (DD-MMM-YYYY)

Diagnosis Verified: Yes No Disclosed: Yes No

LMP: (DD-MMM-YYYY) Pregnant: Yes No

Presenting Complaints

Presenting Complaints: None

TB Screening: Performed Not Documented

Medical History

Disease History: None Not Documented

Anaemia	Select	
Drug/Alcohol Abuse	Select	
Kidney Disease	Select	
Liver Disease	Select	
Other	Select	

Drug Allergies/Toxicities:

None Not Documented Sulfa Drugs Other (specify):

Current Long Term Medications (select all that apply):

- Sulfa/TMP
- TB Rx (Specify)
- Other (Specify)

HIV-Related History

Lowest CD4: None Not Documented

c/mm³ % Date: (DD-MMM-YYYY)

CD4 Prior to Starting ARVs: None Not Documented

c/mm³ % Date: (DD-MMM-YYYY)

Most Recent CD4: None Not Documented

c/mm³ % Date: (DD-MMM-YYYY)

Pre-therapy Viral Load: None Not Documented

c/ml Date: (DD-MMM-YYYY)

ARV Exposure: None Not Documented Enter ARV Exposure

HIV-Associated Conditions: None Not Documented Enter HIV-Associated Conditions

Physical Exam

Temp: C RR: bpm HR: bpm BP: / (mm/Hg) HT: cm WT: kg Pain: Select

WAB Stage: Select WHO Stage: Select

Assessment, Plan and Regimen

Assessment:

No Illness Found HIV-Related Illness/OI Non-HIV-Related Illness

Plan:

Lab evaluation/TB screen OI prophylaxis/treatment Treatment Preparation Other

*ARV Therapy: Select

Clinical Notes

10.1.6 Follow up Education

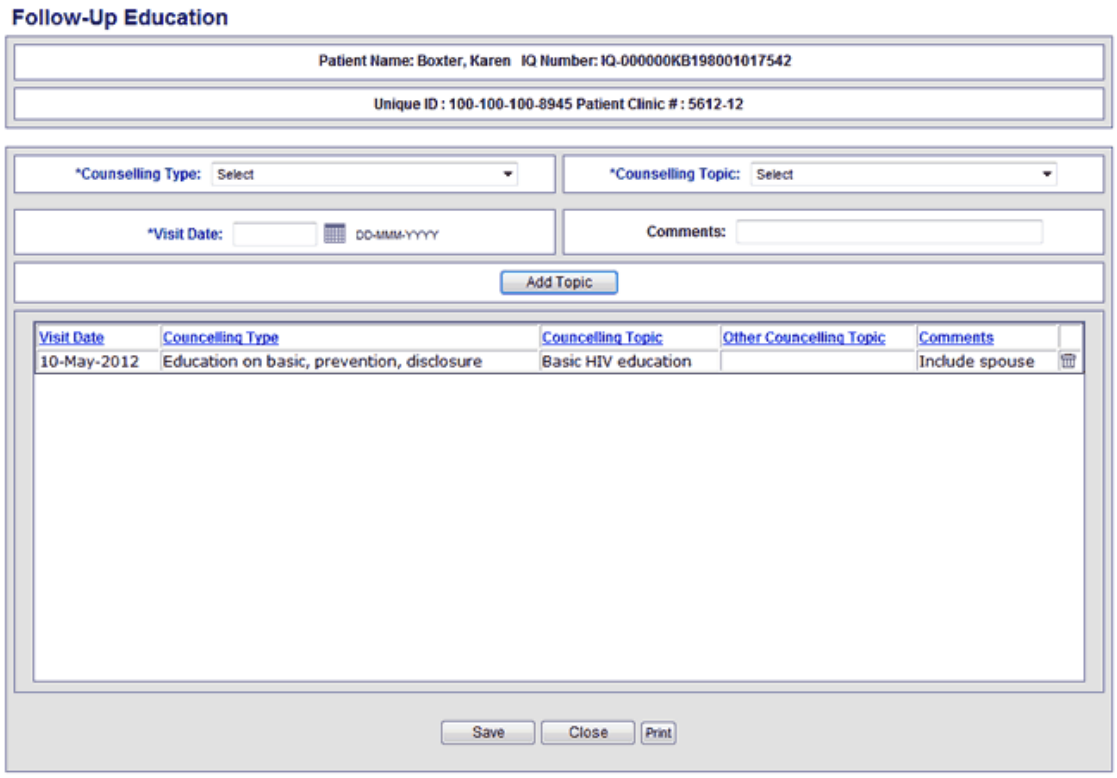
Fill in a Follow-up Education Form

1. From the Additional Forms link, click on the Follow-up Education link
2. Select the Counseling Type, Counseling Topic, and enter the visit date and any comments. Or, if the counseling type is not in the list, select Other, and enter the information. (To add a counseling type and/or topic to the select list, see Customize Lists)
3. Click the Add Topic button to save and add the topic. The follow-up education information displays in the grid below.
4. Click Save to return to the patient home page

Update a Follow-up Education Form

1. From the Additional Forms link, click on Follow-up Education link
2. To update an existing follow-up education entry, click on the row of the follow-up education you want to update. The follow-up education information will display.
3. Update the fields and click the Update Topic button.
4. To delete a follow-up education session, click on the trash can icon at the right side on each row.
5. Click Save to return to the patient home page.

View the Follow up Education Form



10.1.7 Adult Pharmacy 3.1 and below

For IQCare versions of 3.1 and below, the pharmacy form is a static form with the ability to dynamically add addition drugs to the form through drug picker lists. The ARV, OI and TB sections have a list of pre-configured fields that the user selects.

The Adult Pharmacy form is split into five sections:

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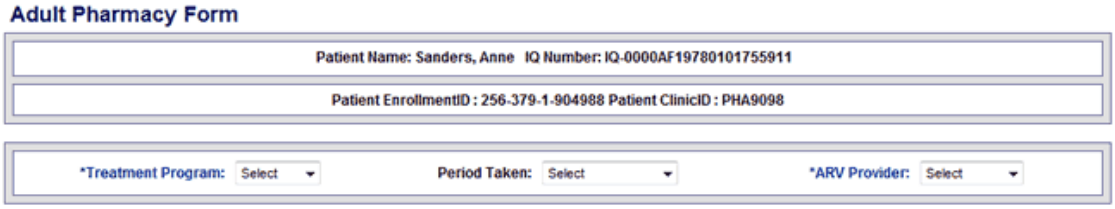
Form Header


Adult Pharmacy Form
Patient Name: Sanders, Anne IQ Number: IQ-0000AF19780101755911
Patient EnrollmentID : 256-379-1-904988 Patient ClinicID : PHA9098
*Treatment Program: Select
Period Taken: Select
*ARV Provider: Select

In the header section of the pharmacy form, you see the patient's name, IQCare number and any other patient number designated for this technical area.

Treatment Program Options:

ART

- Enables the ARV medication section of the form
- Disables the Prophylaxis check boxes
- The regimen line is a required field.

PMTCT

- Enables the ARV medication section of the form
- Enables the Prophylaxis check boxes
- Sets the business rule that the prophylaxis check boxes must be checked for the ARV medication section
- The regimen line is not a required field.

PEP

- Enables the ARV medication section of the form
- Enables the Prophylaxis check boxes
- Sets the business rule that the prophylaxis check boxes must be checked for the ARV medication section
- The regimen line is not a required field

Non-ART

- Disables the ARV medication section of the form

Period Taken

- This is targeted to PMTCT patients when it's important to know when she had taken ARV medications. Options are: During pregnancy, During labor, Post Natal

ARV Providers Options:

- Government, USG, Self Pay and Other
- This field is used in the Track 1 Table 2, cell ss to determine if drugs have been provided by the US government
- This select list can be customized.

ARV Medications

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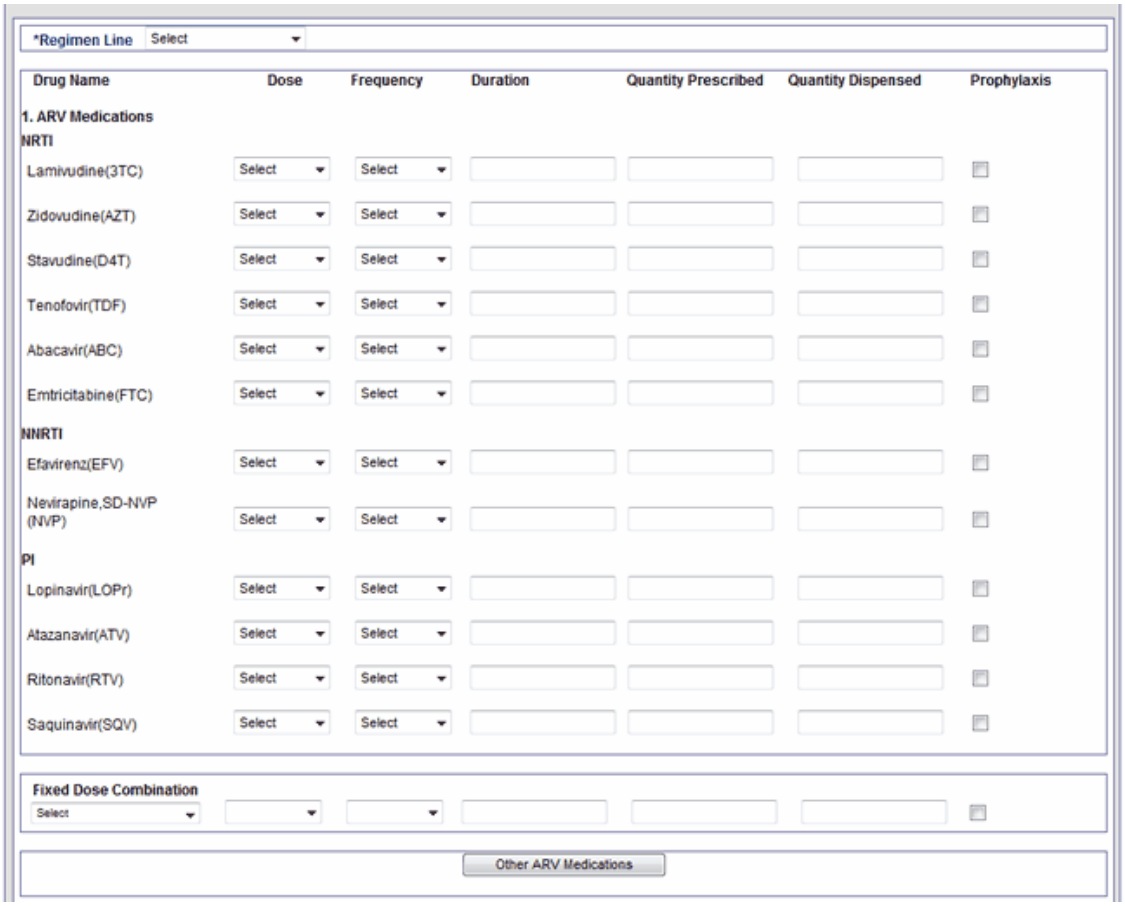

- If the ART treatment program is selected, the regimen line is required.
- If the non-ART treatment program is selected then then the ARV drug section is disabled.
- If PMTCT or PEP treatment program is selected, then the prophylaxis check boxes are enabled.

To make up an ARV regimen:

- Individual ARV drugs can be selected
- Fixed dose combinations can be selected
- A mixture of individual and fixed dose combinations can be selected
- You can use the Other ARV Medications button to see the entire available list of ARVs in IQCare; if the drug you are looking for is not in the list, you can configure a new drug. See Drugs Custom List for more information on configuring new or updating existing drugs.
- You must specify the regimen line of the drug regimen you select.

ARV Changed or Stopped Business Rules for the ARV Medications Section

The ARV Therapy select list found in the Initial Evaluation and the ART Follow up forms (HIV Static Form Set) is checked upon saving the pharmacy form.

If ARV Therapy =

- Continue - then the ARV regimen saved in the form must be the same as the ARV regimen in the prior form
- Change - then the ARV regimen saved in the form must be different from the ARV regimen in the prior form
- Stopped - then the ARV section of the form is disabled and ARV medications cannot be prescribed

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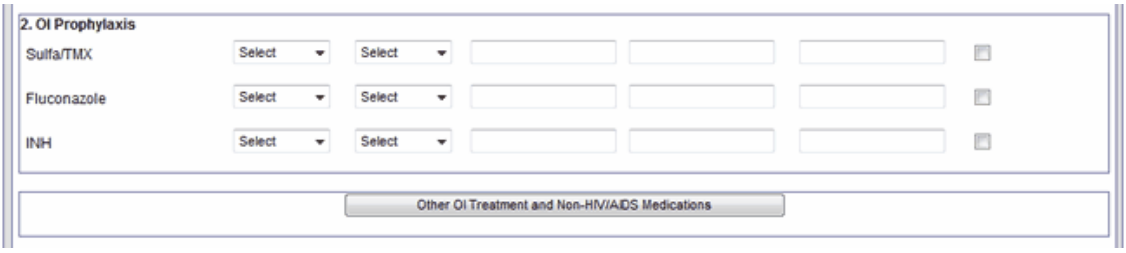
OI Prophylaxis and Treatment



- The standard OI prophylaxis and treatment drugs are in the form.
- If the drug you want is not on the form, use the Other Treatment and Non-HIV/AIDS medications button to see the entire list of available OI drugs in IQCare
- The check box indicates that the drug is prescribed for prophylaxis purposes

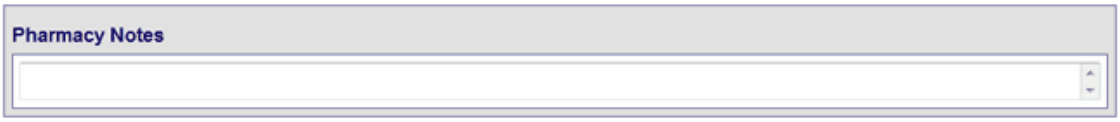
TB Treatment

The list of combination regimens available is driven from the TB Regimen custom list. If you don't see the combination you want, you can add the combination so that it displays as a standard regimen, or you can use the Other TB Medications button to select one or more drugs to make up the regimen.

Vitamins and Other Drugs

This section, targeted to pregnant mothers has the standard set of vitamins and other drugs given on a regular basis.

Pharmacy Notes



This section was added for those clinics using a paperless system and allow the clinician to provide instructions to the pharmacist.

Approvals and Signatures

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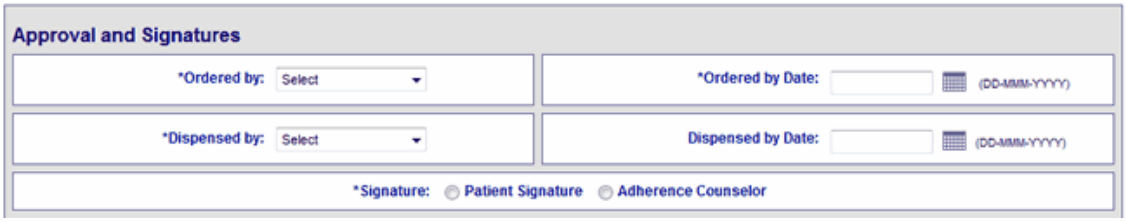

In paperless mode, the form can be saved with only the Ordered by and Ordered by Date, by the clinician. The pharmacist entered the Dispensed by and Dispensed by Date upon dispensing the drugs.

Filling in the pharmacy form in Paperless mode

Note for the Paperless facility the pharmacy form can be filled in, in two steps. First the clinician can prescribe the drugs, entering the dose, frequency and quantity prescribed. The clinician can save the form with the Ordered by and Ordered by date filled in. Then the pharmacist opens the form, see the drugs that have been prescribed, enters the amount dispensed and fills in the dispensed by and dispensed by date.

Fill in a New Adult Pharmacy Form

1. From the Patient Home Page, click on the Create New Form link and select the Adult Pharmacy form.
2. Select the Treatment Program and the ARV Provider. Select the Period Taken if the patient is a pregnant woman or has recently given birth.
3. Fill in the ARV Medications part of the form by filling in the strength, frequency, duration, total quantity, quantity dispensed.
4. If the ARV medication is not found in the first part of the form, click the Other ARV Medications button.
   a. A drug picker will display a list of ARV medications (generic and trade names)
   b. Select one or more ARV medications on the left and move the selection(s) to the right
   c. Click Submit to save; the system displays the selections as new entry options in the pharmacy form
   d. Select the frequency, duration, total quantity, quantity dispensed
5. Fill in the OI section as needed.
6. If the OI drug is not found in the form, click on the OI Treatment and Other Medications button to add these kinds of drugs
   a. A drug picker will display a list of all Non-ARV medications
   b. Select one or more medications on the left and move the selection(s) to the right
   c. Click Submit to save; the system displays the selections as new entry options in the pharmacy form
   d. Select the frequency, duration, total quantity, quantity dispensed
7. Fill in the TB regimen section as needed
8. Fill in the Vitamin section as needed
9. Fill in the Ordered by, Ordered by date, Dispensed by, Dispensed by date and the patient signature option
10. Click Save
11. IQCare displays a message alerting you of any required fields not filled in
12. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update an Adult Pharmacy form

1. To access a previously filled in Adult Pharmacy form click on View Existing Forms and find the

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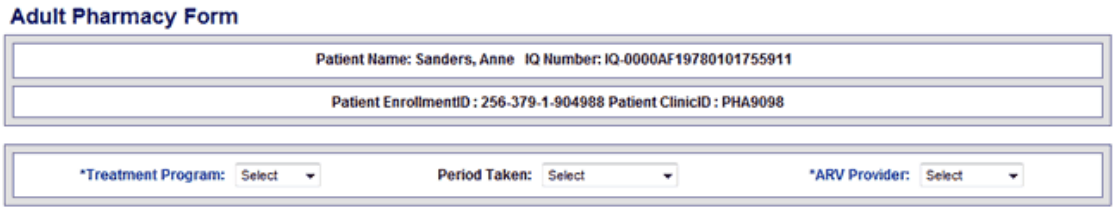
Adult Pharmacy form you want to update and click the link
2. Update the form
3. Click Save

10.1.8 Adult Pharmacy 3.2 and above

For IQCare versions of 3.2 and above, the pharmacy form is almost completely dynamic. Drugs are selected from a the IQCare drug list and as many rows (drugs) as the you need to add, you can add. ARV, OI and TB drugs display in separate sections if they are selected.

The Adult Pharmacy form is split into five sections:

▼ **Form Header**


Adult Pharmacy Form
Patient Name: Sanders, Anne IQ Number: IQ-0000AF19780101755911
Patient EnrollmentID : 256-379-1-904988 Patient ClinicID : PHA9098
*Treatment Program: Select
Period Taken: Select
*ARV Provider: Select

In the header section of the pharmacy form, you see the patient's name, IQCare number and any other patient number designated for this technical area.

Treatment Program Options:

ART

- Enables the ARV medication section of the form
- Disables the Prophylaxis check boxes
- The regimen line is a required field.

PMTCT

- Enables the ARV medication section of the form
- Enables the Prophylaxis check boxes
- Sets the business rule that the prophylaxis check boxes must be checked for the ARV medication section
- The regimen line is not a required field.

PEP

- Enables the ARV medication section of the form
- Enables the Prophylaxis check boxes
- Sets the business rule that the prophylaxis check boxes must be checked for the ARV medication section
- The regimen line is not a required field

Non-ART

- Disables the ARV medication section of the form

Period Taken

- This is targeted to PMTCT patients when it's important to know when she had taken ARV medications. Options are: During pregnancy, During labor, Post Natal

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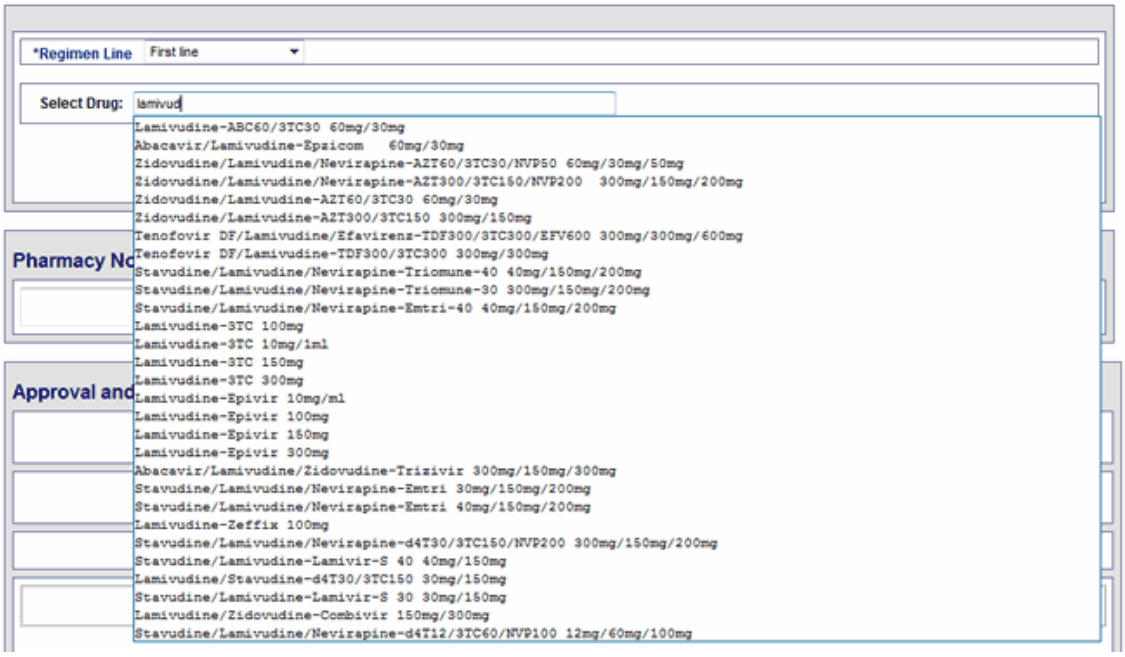
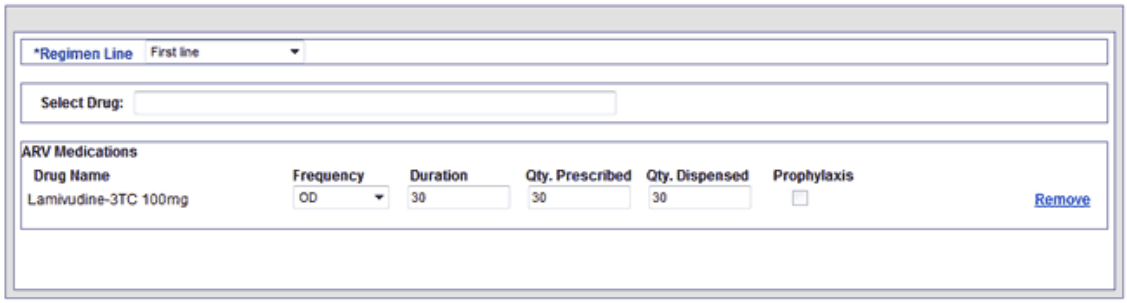
ARV Providers Options:

- Government, USG, Self Pay and Other
- This field is used in the Track 1 Table 2, cell ss to determine if drugs have been provided by the US government
- This select list can be customized.

Adding Drugs to the Form



To add any drug to the form, simply start typing the trade or generic name of the drug. All of the drugs in the database with the drug will display.
In this example, "Lamivud" has been typed into the Select Drug box and all of the individual trade and generic as well as fixed dose combinations display and can be selected.



Upon selection, the drug name along with the frequency, duration, quantity prescribed, quantity dispensed and prophylaxis check box displays. ARV drugs display in their own section.
If the drug you selected is not correct, use the Remove link to remove the row.

Continue add drugs of any type of drug in any order you like. They are displayed in three sections depending on the drug type.

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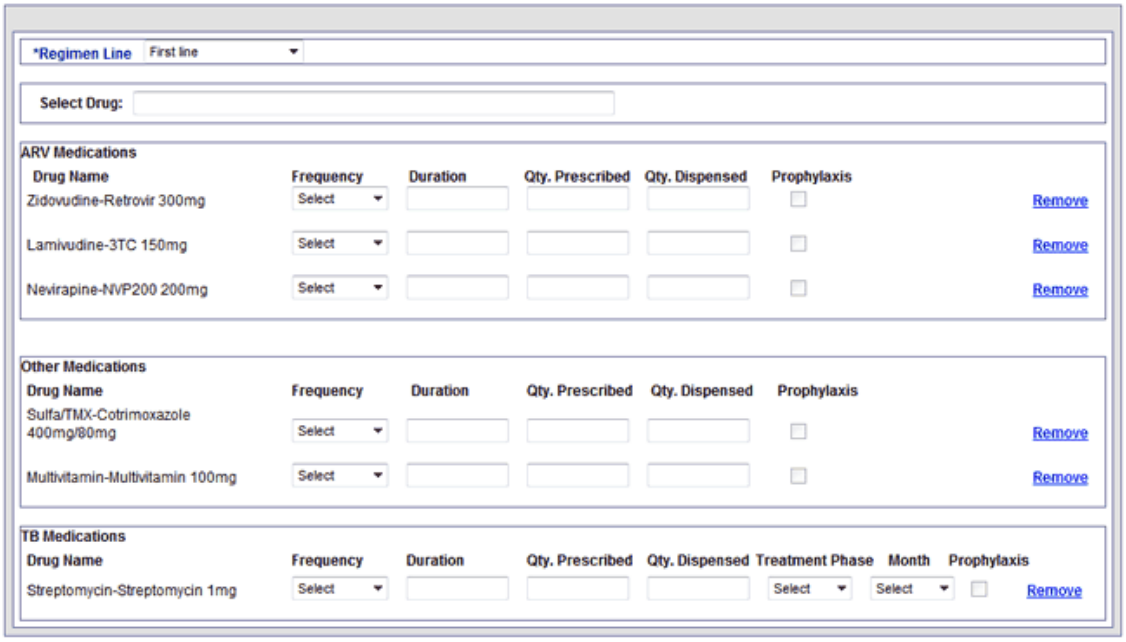


Drug Type Business Rules

ARVs

ARV Changed or Stopped Business Rules for the ARV selected drugs

The ARV Therapy select list found in the Initial Evaluation and the ART Follow up forms (HIV Static Form Set) is checked upon saving the pharmacy form.

If ARV Therapy =

- Continue - then the ARV regimen saved in the form must be the same as the ARV regimen in the prior form
- Change - then the ARV regimen saved in the form must be different from the ARV regimen in the prior form
- Stopped - then the ARV section of the form is disabled and ARV medications cannot be prescribed

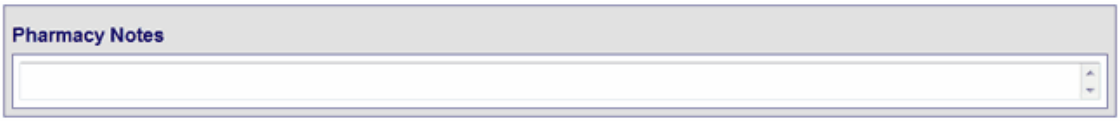
OIs and Other Drugs

- The check box indicates that the drug is prescribed for prophylaxis purposes
- Multi vitamins and other supplements targeted to pregnant women must be selected individually.

TB

TB Regimens are entered either as individual drugs or as fixed dose combinations, depending on how the drug is configured in the drug list.

Pharmacy Notes



This section was added for those clinics using a paperless system and allow the clinician to provide instructions to the pharmacist.

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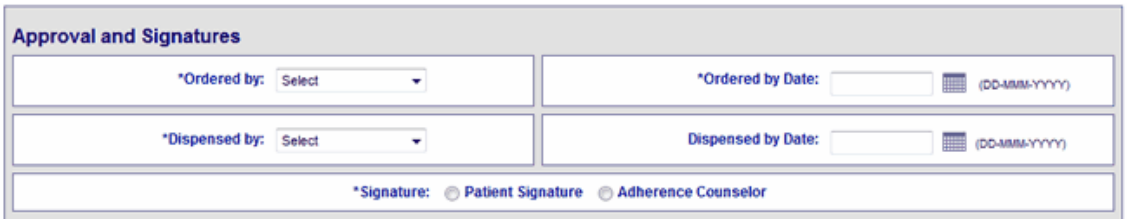
Approvals and Signatures



In paperless mode, the form can be saved with only the Ordered by and Ordered by Date, by the clinician. The pharmacist entered the Dispensed by and Dispensed by Date upon dispensing the drugs.

Filling in the pharmacy form in Paperless mode

Note for the Paperless facility the pharmacy form can be filled in, in two steps. First the clinician can prescribe the drugs, entering the dose, frequency and quantity prescribed. The clinician can save the form with the Ordered by and Ordered by date filled in. Then the pharmacist opens the form, see the drugs that have been prescribed, enters the amount dispensed and fills in the dispensed by and dispensed by date.

Fill in a New Adult Pharmacy Form

1. From the Patient Home Page, click on the Create New Form link and select the Adult Pharmacy form.
2. Select the Treatment Program and the ARV Provider. Select the Period Taken if the patient is a pregnant woman or has recently given birth.
3. In the Select Drug box, enter the trade or generic name of the drug. Select the drug and hit enter on your keyboard.
4. The system displays the frequency, duration, total quantity, quantity dispensed and prophylaxis check box
5. Repeat entering drugs until complete
6. If you have incorrectly selected a drug, click on the Remove link to remove the row.
7. Enter data for all of the fields on each row of each drug.
8. Fill in the Ordered by, Ordered by date, Dispensed by, Dispensed by date and the patient signature option
9. Click Save
   - IQCare displays a message alerting you of any required fields not filled in
   - IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update an Adult Pharmacy form

1. To access a previously filled in Adult Pharmacy form click on View Existing Forms and find the Adult Pharmacy form you want to update and click the link
2. Update the form
3. Click Save

10.1.9 Paediatric Pharmacy 3.1 and below

For IQCare versions of 3.1 and below, the pharmacy form is a static form with the ability to dynamically add addition drugs to the form through drug picker lists. The ARV, OI and TB

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sections have a list of pre-configured fields that the user selects.

Filling in the Paediatric Pharmacy form is very similar to filling in the Adult Pharmacy form.The major difference is that there are some additional fields which help define the correct formulation of the drug.

Fill in a new Paediatric Pharmacy form

1. From the Patient Home Page, click on the Create New Form link and select the Paediatric Pharmacy form.
2. Select the program and the ARV Provider. Select the Period Taken if the patient is an exposed infant.
3. Fill in the ARV Medications part of the form by filling in the formulation, single dose, and frequency. The total dose will be calculated based on the single dose and frequency input. Complete the data entry for the drug by filling in the duration, total quantity and quantity dispensed.
4. If ARV medication is not found in the first part of the form, click the Other ARV Medications button.
    a. A drug picker will display a list of ARV medications (trade names)
    b. Select one or more ARV medications on the left and move the selection(s) to the right
    c. Click Submit to save; the system displays the selections as new entry options in the pharmacy form
    d. Select the frequency, duration, total quantity, quantity dispensed
5. Click on the OI Treatment and Other Medications button to add these kinds of drugs
    a. A drug picker will display a list of all Non-ARV medications
    b. Select one or more medications on the left and move the selection(s) to the right
    c. Click Submit to save; the system displays the selections as new entry options in the pharmacy form
    d. Fill-in the formulation, single dose, frequency, duration, total quantity and quantity dispensed
6. Fill in the Ordered by, Ordered by date, Dispensed by, Dispensed by date and the patient signature option
7. Click Save
8. IQCare displays a message alerting you of any required fields not filled in
9. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update a Paediatric Pharmacy form

When pulling up a previously saved pharmacy form, if the same ARV medication is selected at the top part of the form and via the Other ARV Medications button depending on the dose and frequency, the display order of the ARV medication may switch.

1. To access a previously filled in Paediatric Pharmacy form click on View Existing Forms and find the Paediatric Pharmacy form you want to update and click the link
2. Update the form
3. Click Save

** Note for the Paperless facility the pharmacy form can be filled in, in two steps. First the clinician can prescribe the drugs, entering the dose, frequency and quantity prescribed. The clinician can save the form with the Ordered by and Ordered by date filled in. Then the pharmacist can open the form, see the drugs that have been prescribed, enter the amount dispensed and fill in the dispensed by and dispensed by date.

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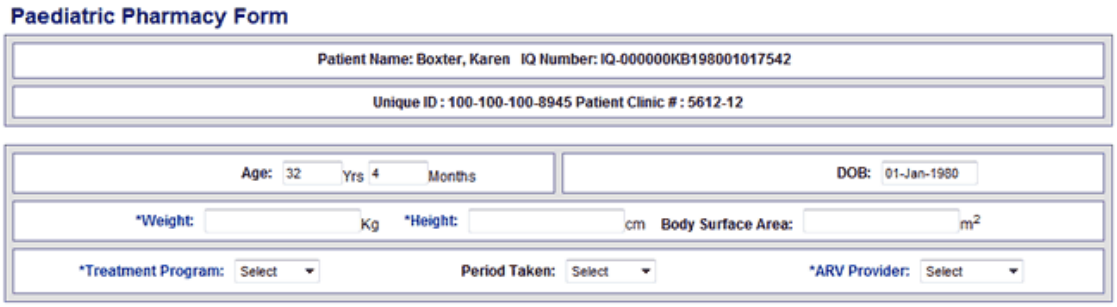
10.1.10 Paediatric Pharmacy 3.2 and above

For IQCare versions of 3.2 and above, the pharmacy form is almost completely dynamic. Drugs are selected from a the IQCare drug list and as many rows (drugs) as the you need to add, you can add. ARV, OI and TB drugs display in separate sections if they are selected.

Filling in the Paediatric Pharmacy form is very similar to filling in the Adult Pharmacy form.The major difference is the header where the with weight and height is collected to aid in determining the correct dose.

Form Header



The Body Surface Area calculation: sqrt(weight * height/3600), units=m^2

See Adult Pharmacy Header Section for the definitions of the treatment program, period taken and ARV provider.

Adding Drugs to the Form

The way you add drugs to the Paediatric Pharmacy form is exactly the same as adding them in the Adult Pharmacy form. Please see that the section on adding drugs for Adult Pharmacy.

Fill in a New Paediatric Pharmacy Form

1. From the Patient Home Page, click on the Create New Form link and select the Paediatric Pharmacy form.
2. Enter the weight and height
3. Select the program and the ARV Provider. Select the Period Taken if the patient is an exposed infant.
4. In the Select Drug box, enter the trade or generic name of the drug. Select the drug and hit enter on your keyboard.
5. The system displays the frequency, duration, total quantity, quantity dispensed and prophylaxis check box
6. Repeat entering drugs until complete
7. If you have incorrectly selected a drug, click on the Remove link to remove the row.
8. Enter data for all of the fields on each row of each drug.
9. Fill in the Ordered by, Ordered by date, Dispensed by, Dispensed by date and the patient signature option
10. Click Save

- IQCare displays a message alerting you of any required fields not filled in
- IQCare displays a message alerting you of a successful save and asks you if you wish to exit

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or stay on the form (for continued field data entry.)

Update a Paediatric Pharmacy form

1. To access a previously filled in Paediatric Pharmacy form click on View Existing Forms and find the Paediatric Pharmacy form you want to update and click the link
2. Update the form
3. Click Save

** Note for the Paperless facility the pharmacy form can be filled in, in two steps. First the clinician can prescribe the drugs, entering the dose, frequency and quantity prescribed. The clinician can save the form with the Ordered by and Ordered by date filled in. Then the pharmacist can open the form, see the drugs that have been prescribed, enter the amount dispensed and fill in the dispensed by and dispensed by date.

10.1.11 Laboratory Order/Results

If the facility is a paperless facility a Laboratory Order form is provided for the clinician to order labs and a Laboratory Results form if available to enter the results. If the facility is non-paperless, only the Laboratory Results form is available.

The Laboratory Results form can be configured using the Lab Configuration feature found in the Administration – Customize List section of the application. This feature allows the User/Administrator to configure the units for each numeric lab result as well as the input range. IQCare provide field level validation for all numeric labs and does not allow the User to enter data outside of the specified range. For more information about the lab configuration, please see Lab Order Form Configuration.

For PMTCT a select list "Period Done" is available to specify when a lab test was done - During pregnancy, During labor, At birth, or Post natal.

▼ **View Laboratory Form (Paper based)**

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Laboratory Order Form

Patient Name: Boxter, Karen IQ Number: IQ-000000KB198001017542

Unique ID : 100-100-100-8945 Patient Clinic # : 5612-12

Preclinic Labs: ☐ Lab to be done on: (DD-MMM-YYYY)

Lab Number: Period Done: Select

ARV Related Labs

Immunology

HIV Rapid Test: Pos Neg ☐ Confirmatory

PCR: Pos Neg

CD4: c/mm^3 percent

RPR/VDRL: Pos Neg FTA: Pos Neg

Viral Load: copies/ml ☐ Undetectable

Store Plasma: ☐ Stored

Haematology

HCT: percent Hb: g/dl

WBC: 10^9 c/L

Diff:

Neut: 10^3 cells/mcl percent

Lymph: 10^3 cells/mcl percent

Mono: 10^3 cells/mcl percent

Eosin: 10^3 cells/mcl percent

Platelets: 10^9 c/L

ESR: mm/hour

Chemistry

AST/SGOT: U/L

ALT/SPGT: U/L

Creatinine: mg/dL

Amylase: U/L

Pregnancy: Pos Neg

Microbiology

Malarial Parasite: Present Absent

Serum Crypto. Ag: Pos Neg

Sputum

Sputum AFB #1: Pos Neg

#2: Pos Neg

#3: Pos Neg

Gram Stain:

Urine

Urinalysis:

Spec Grav: No units

Glucose: No units

Ketone: No units

Protein: No units

Leuk Est: No units

Nitrate: No units

Blood: No units

Urinalysis:

Urine Microscopic Blood: Select Urine Microscopic WBC: Select

Urine Microscopic Bact: Select

Urine Microscopic Casts:

☐ Hyaline

☐ Granular

☐ RBC

☐ WBC

☐ Waxy

Culture/Sensitivity:

Stool O/P:

Pos Neg

Stool Description:

CSF

Cryptococcal Ag: Pos Neg

CSF India Ink: Pos Neg

CSF Gram Stain: Pos Neg

Culture:

Cell count: RBC's: cell/microscope field

WBC's: cell/microscope field

Neutrophils: cell/microscope field

Lymphocytes: cell/microscope field

Biochemistry: Glucose: mg/dL Protein: mmol/L

Chest X-Ray

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Fill in a Laboratory Order Form (Paperless)

1. From the Patient Home Page, click on the Create New Form link and select the Lab Order form.
2. Check the labs you want to order
3. Fill in the Ordered by, Ordered by date
4. Click Save
5. IQCare displays a message alerting you of any required fields not filled in
6. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Fill in a New Laboratory Results Form (Non-paperless)

1. From the Patient Home Page, click on the Create New Form link and select the Lab Results form.
2. Fill in the laboratory results
3. If there are additional labs, click the Additional Labs button.
    a. A lab picker will display a list of additional labs to select from
    b. Select one or more additional labs on the left and move the selection(s) to the right
    c. Click Submit to save; the system displays the selections as new entry options in the Lab Order form
    d. Fill in the lab results for these labs as well if they have been financed by AIDSRelief
4. Fill in the Ordered by, Ordered by date, Reported by, Reported by date
5. Click Save
6. IQCare displays a message alerting you of any required fields not filled in
7. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Fill in a New Laboratory Results Form (Paperless)

1. From the View Existing Forms view, find the Lab Results form with the correct date and click on the link to open the form.
2. Fill in the laboratory results
3. Fill in the Reported by, Reported by date
4. Click Save
5. IQCare displays a message alerting you of any required fields not filled in
6. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update a Laboratory Results Form (Paperless or Non-Paperless)

1. To access a previously filled in Lab Results form click on View Existing Forms and find the Lab Order form you want to update and click the link
2. Update the form
3. Click Save

10.1.12 ART Follow-Up

This form is for patients on ARV Medication.

Fill in a New ART Follow-up Form

1. From the Patient Home Page, click on the Create New Form link and select the ART Follow-up form.
2. Fill in the form, making sure you fill in the required fields. Note that some of the fields will be auto populated.
3. Click Save

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4. IQCare displays a message alerting you of any required fields not filled in
5. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update an ART Follow-up Form

1. To access a previously filled in ART Follow-up form click on View Existing Forms and find the ART Follow-up form you want to update and click the link
2. Update the form
3. Click Submit

**Note for the Paperless Facility text fields are added to the ART Follow up form so that clinicians can keep notes. These notes can be queried using the custom reports.

▼ **View ART Follow up Form**

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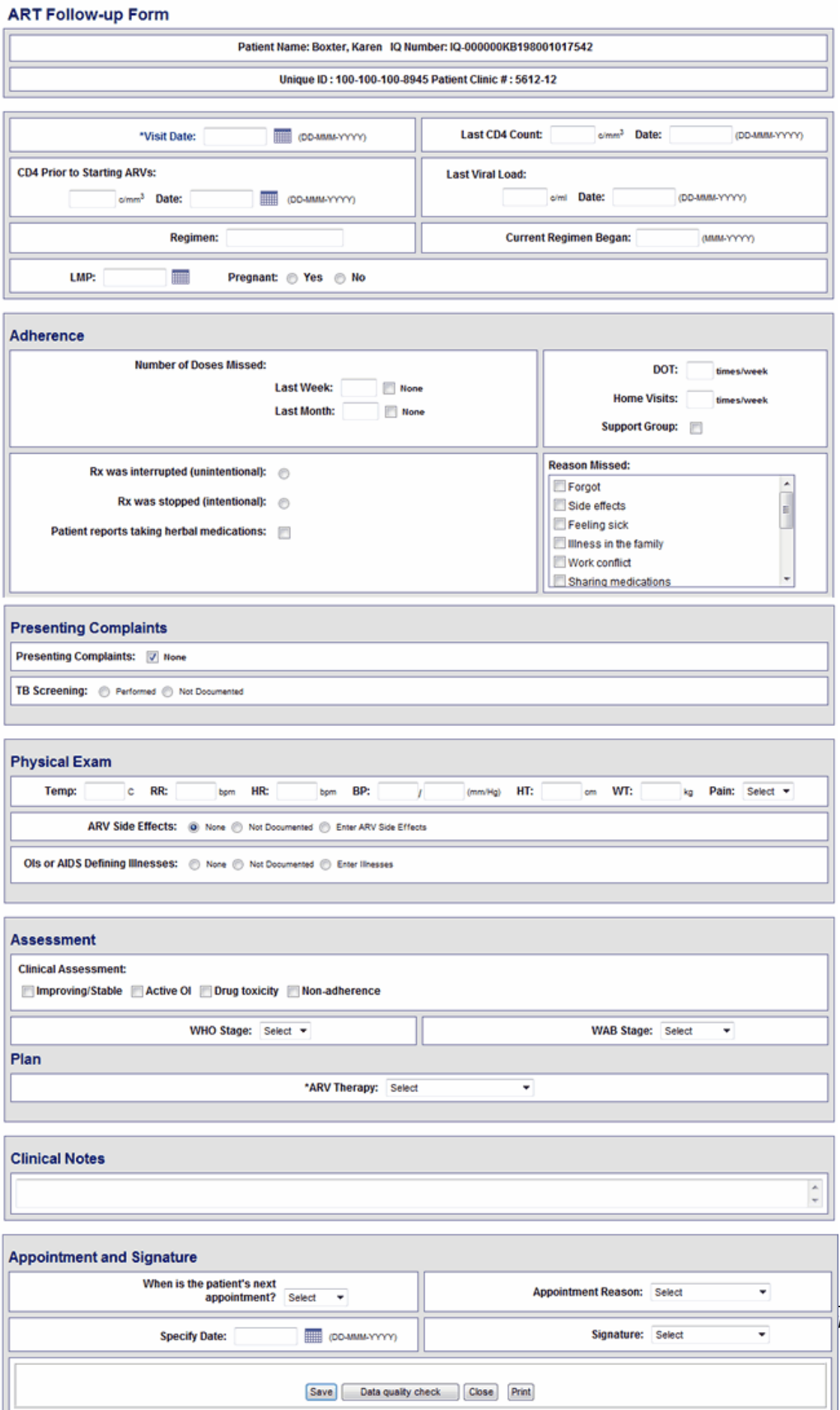
ART Follow-up Form
Patient Name: Boxter, Karen IQ Number: IQ-000000KB198001017542
Unique ID : 100-100-100-8945 Patient Clinic # : 5612-12
*Visit Date: (DD-MMM-YYYY)
Last CD4 Count: c/mm3 Date: (DD-MMM-YYYY)
CD4 Prior to Starting ARVs: c/mm3 Date: (DD-MMM-YYYY)
Last Viral Load: c/ml Date: (DD-MMM-YYYY)
Regimen:
Current Regimen Began: (MMM-YYYY)
LMP:
Pregnant: Yes No
Adherence
Number of Doses Missed:
Last Week: None
Last Month: None
DOT: times/week
Home Visits: times/week
Support Group:
Rx was interrupted (unintentional):
Rx was stopped (intentional):
Patient reports taking herbal medications:
Reason Missed:
Forgot
Side effects
Feeling sick
Illness in the family
Work conflict
Sharing medications
Presenting Complaints
Presenting Complaints: None
TB Screening: Performed Not Documented
Physical Exam
Temp: C RR: bpm HR: bpm BP: / (mm/Hg) HT: cm WT: kg Pain: Select
ARV Side Effects: None Not Documented Enter ARV Side Effects
OIs or AIDS Defining Illnesses: None Not Documented Enter Illnesses
Assessment
Clinical Assessment:
Improving/Stable Active OI Drug toxicity Non-adherence
WHO Stage: Select
WAB Stage: Select
Plan
*ARV Therapy: Select
Clinical Notes
Appointment and Signature
When is the patient's next appointment? Select
Appointment Reason: Select
Specify Date: (DD-MMM-YYYY)
Signature: Select
Save
Data quality check
Close
Print

10.1.13 Non-ART Follow-Up

This form is for patients not on ARV medication. The form has two sections: a section with clinical questions and a section allowing you to select non-ARV medications so that you do not need to fill out an additional pharmacy form.

Fill in a New Non-ART Follow-up Form

1. From the Patient Home Page, click on the Create New Form link and select the Non-ART Follow-up form.
2. Fill in the clinical section of the form. Note that some of the fields will be auto populated.
3. Fill in the pharmacy section of the form, making sure you fill in the Ordered by, Ordered by date, Dispensed by, Dispensed by date and signature
4. Click Save
5. IQCare displays a message alerting you of any required fields not filled in
6. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update a Non-ART Follow-up Form

1. To access a previously filled in Non-ART Follow-up form click on View Existing Forms and find the Non-ART Follow-up form you want to update and click the link
2. Update the form
3. Click Save

**Note for the Paperless Facility text fields are added to the Non-ART Follow up form so that clinicians can keep notes. These notes can be queried using the custom reports.

10.1.14 Home Visit

Fill in a new Home Visit form

1. From the Patient Home Page, click on the Home Visit Form link and select the Home Visit form.
2. Fill in the fields.
3. Click Save
4. IQCare displays a message alerting you of any required fields not filled in
5. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update a Home Visit form

1. To access a previously filled in Home Visit form click on View Existing Forms and find the Home Visit form you want to update and click the link
2. Update the form
3. Click Save

▼ **View Home Visit Form**

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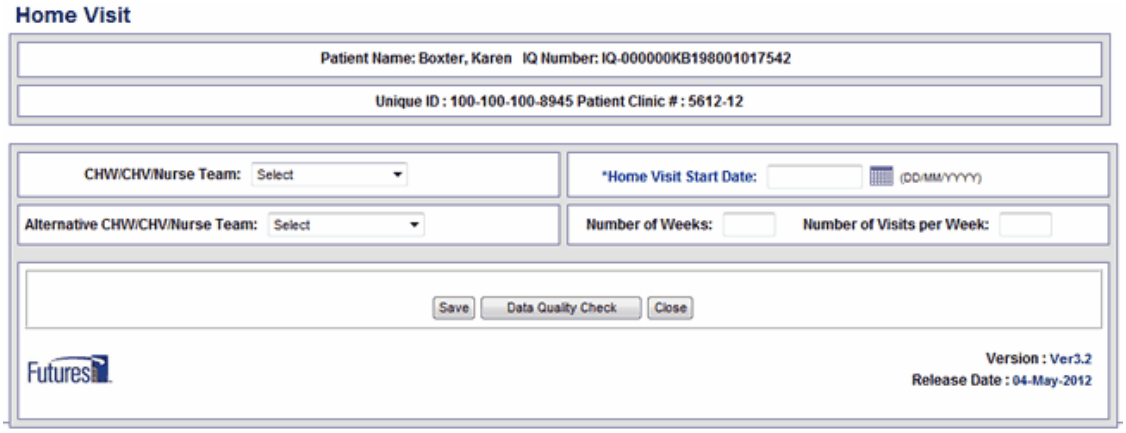

10.1.15 Care Ended

The Care Ended form is primarily used to record that care has ended for the patient and the associated reasons. However, you can use the form to track absences in treatment. IQCare allows for multiple Care Ended forms.

In the form there are two care ended questions: “Patient ART ended but still on care?” and “Patient care ended?” If either of these questions are marked as “Yes”, then the form opens to display an additional set of fields, many of them are required for saving the form.

If the patient’s care has ended in the program, the status of the patient is changed from Active to Care Ended. You can view previously filled in forms for care ended patients but you can not edit the forms when the status of the patient is care ended. If you wish to enter any new forms for a patient with a status of Care Ended, you must reactivate the patient

Fill in a New Care Ended Form

1. From the Patient Home Page, click on the Create New Form link and select the Care Ended form.
2. The Last appointment date and the Last contact date will be auto populated if the data is available. Both fields are editable and you can enter a date.
3. Fill-in the form noting the additional required fields.
4. Click Save
5. If the patient’s program has ended, then the patient status changes from Active to Care Ended
6. IQCare displays a message alerting you of any required fields not filled in
7. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update a Care Ended Form

The Care Ended from is not editable if the answer to the program Care Ended question = “Yes”. The save button is grayed out. You can update a Care Ended form if the patient is still enrolled in the program.

1. To access a previously filled in Care Ended form click on View Existing Forms and find the Care Ended form you want to update and click the link
2. Update the form
3. Click Save

View Care Ended Form

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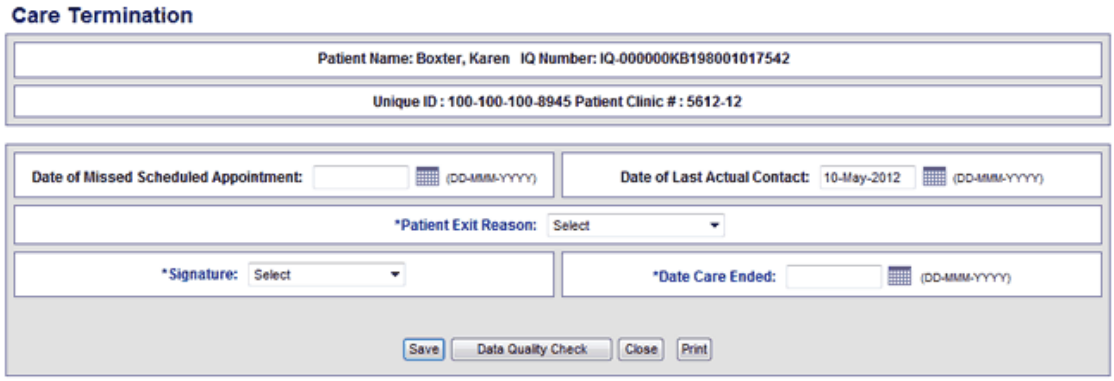
This screen shot of the Care Ended form shows the minimum configuration. You can configure this form with additional fields. For more information about how to configure the Care Ended form, please see Manage Care Ended Forms.



10.2 PMTCT Form Set

A facility's PMTCT form set comprises of two types of forms:
1. Static forms
2. Dynamic forms created with Form Builder and specific to your PMTCT technical area

The Static forms are the forms that do not change regardless of the form builder forms you create for collecting PMTCT or Exposed Child data. We call these static forms because you can not change the form; you can only add custom fields to these forms. The field labels, field types, sections and order can not be changed.

- Adult Pharmacy - this form is the same as the Adult Pharmacy form used in the HIV Care program. However some additional business rules are applied to tailor the form for PMTCT use.
- Paediatric Pharmacy -- Also same as the Paediatric Pharmacy form
- Laboratory - the same as the laboratory form used in the HIV Care program
- Care Tracking -- the same form as used in the HIV Care program (Non-ART) but tailored for PMTCT patients

The Dynamic forms are those that the you create through the form builder. In order to run PMTCT reports such as the Track 1.0 PMTCT or Track 1.0 Exposed Child report, you must have at least an ANC and a Labour & Delivery register form published. See PMTCT form naming conventions for more information.

10.2.1 Adult and Peds Pharmacy

The adult and paediatric pharmacy forms for PMTCT are the same as for the HIV Care program except you can only dispense ARVs for prophylaxis and not for treatment.

You must check the prophylaxis box in order to dispense ARVs and save the form.

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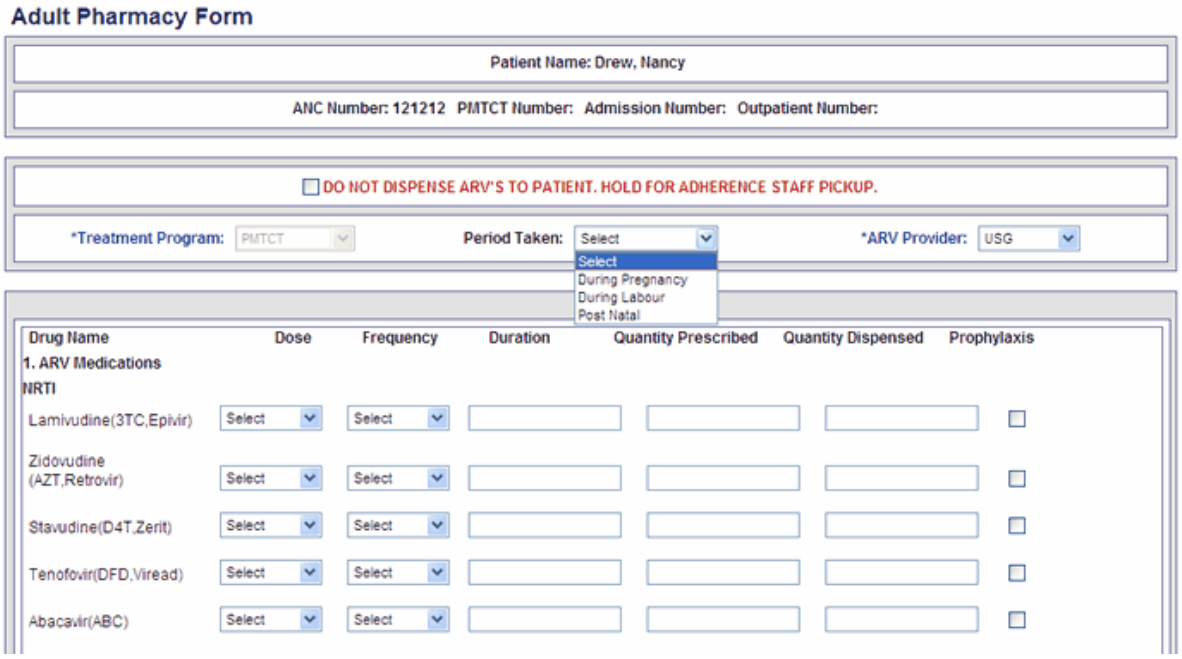
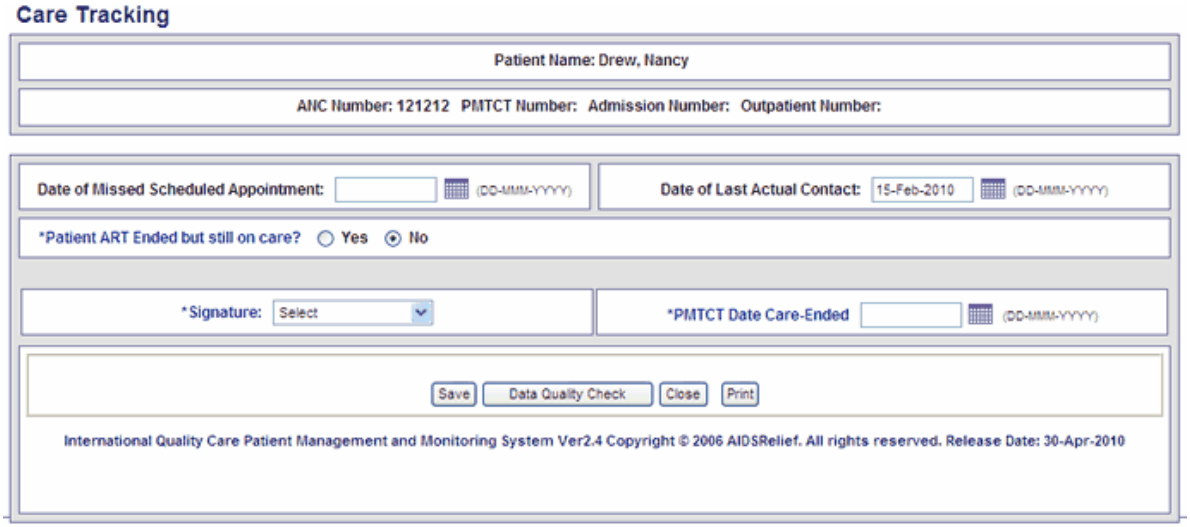


10.2.2 Care Tracking

The Care Tracking form for the PMTCT is the same as for the HIV Care but it has been slightly modified for PMTCT.


Care Tracking
Patient Name: Drew, Nancy
ANC Number: 121212 PMTCT Number: Admission Number: Outpatient Number:
Date of Missed Scheduled Appointment: (DD-MMM-YYYY)
Date of Last Actual Contact: 15-Feb-2010 (DD-MMM-YYYY)
*Patient ART Ended but still on care? Yes No
*Signature: Select
*PMTCT Date Care-Ended (DD-MMM-YYYY)
Save
Data Quality Check
Close
Print
International Quality Care Patient Management and Monitoring System Ver2.4 Copyright © 2006 AIDSRelief. All rights reserved. Release Date: 30-Apr-2010

10.3 HIV/ART Care Form Set (Uganda)

This MOH Blue Card form set is based on the Uganda Blue Care used by MOH facilities.

The form set includes these forms:

- Prior ART HIV Care
- ART Care
- HIV Care/ART Encounter
- Exposed Infant
- Adult Pharmacy

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Paediatric Pharmacy
Laboratory
Follow up Education

10.3.1 Prior ART HIV Care

- This is a one-time form. There is only one instance of this form for a patient. The User enters the information for the patient and saves.
- To update the data, find the form in View Existing Forms and open the form. Any data that was entered previously will display.
- Updates to the data will overwrite the existing data.
- See the data dictionary for the data field field types and business rules for this form.

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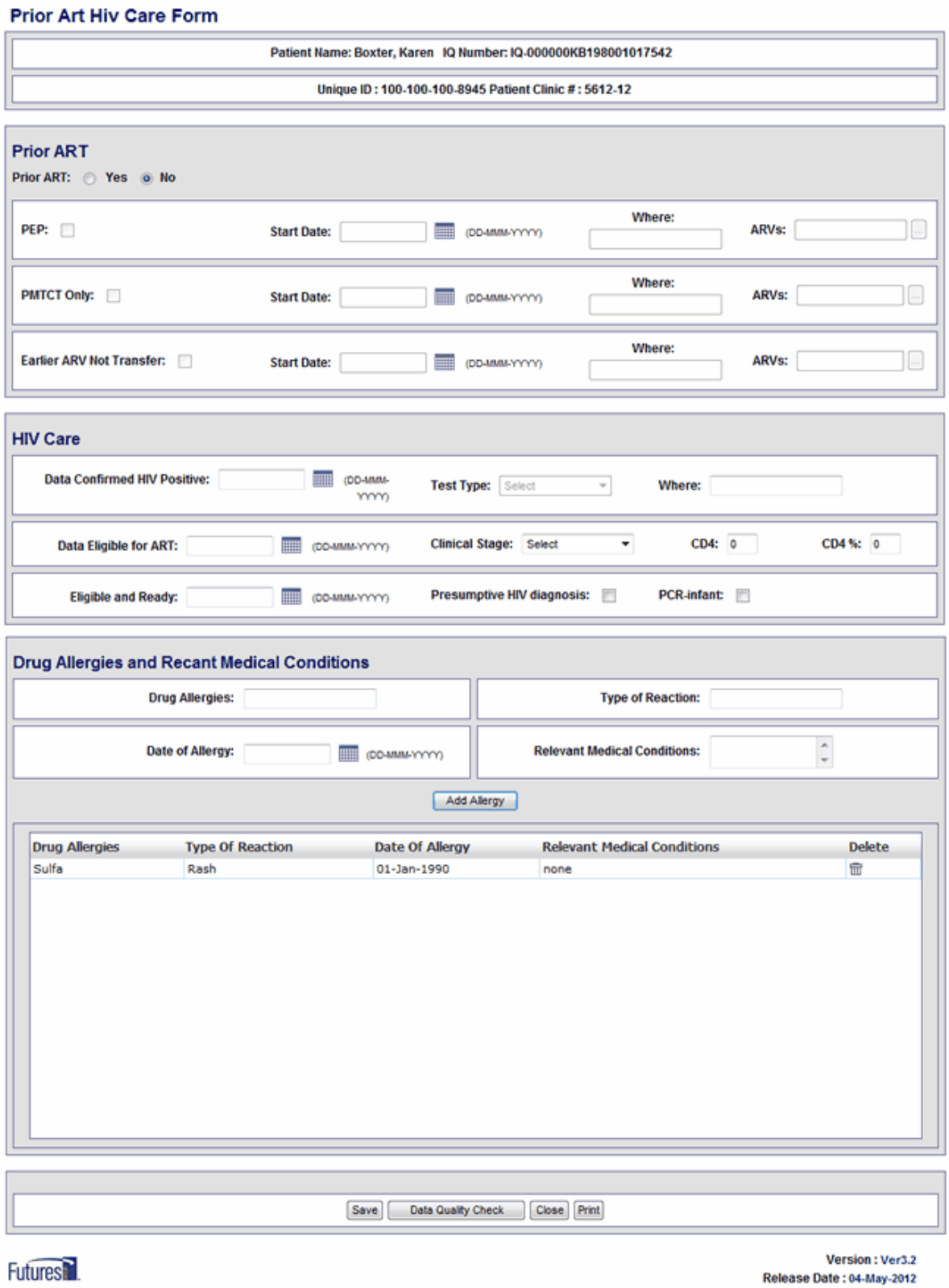
Prior Art Hiv Care Form
Patient Name: Boxter, Karen IQ Number: IQ-000000KB198001017542
Unique ID : 100-100-100-8945 Patient Clinic # : 5612-12
Prior ART
Prior ART: Yes No
PEP: Start Date: (DD-MMM-YYYY) Where: ARVs:
PMTCT Only: Start Date: (DD-MMM-YYYY) Where: ARVs:
Earlier ARV Not Transfer: Start Date: (DD-MMM-YYYY) Where: ARVs:
HIV Care
Data Confirmed HIV Positive: (DD-MMM-YYYY) Test Type: Select Where:
Data Eligible for ART: (DD-MMM-YYYY) Clinical Stage: Select CD4: 0 CD4 %: 0
Eligible and Ready: (DD-MMM-YYYY) Presumptive HIV diagnosis: PCR-infant:
Drug Allergies and Recant Medical Conditions
Drug Allergies: Type of Reaction:
Date of Allergy: (DD-MMM-YYYY) Relevant Medical Conditions:
Add Allergy
Drug Allergies
Type Of Reaction
Date Of Allergy
Relevant Medical Conditions
Delete
Sulfa
Rash
01-Jan-1990
none
Save
Data Quality Check
Close
Print
Futures
Version : Ver3.2
Release Date : 04-May-2012

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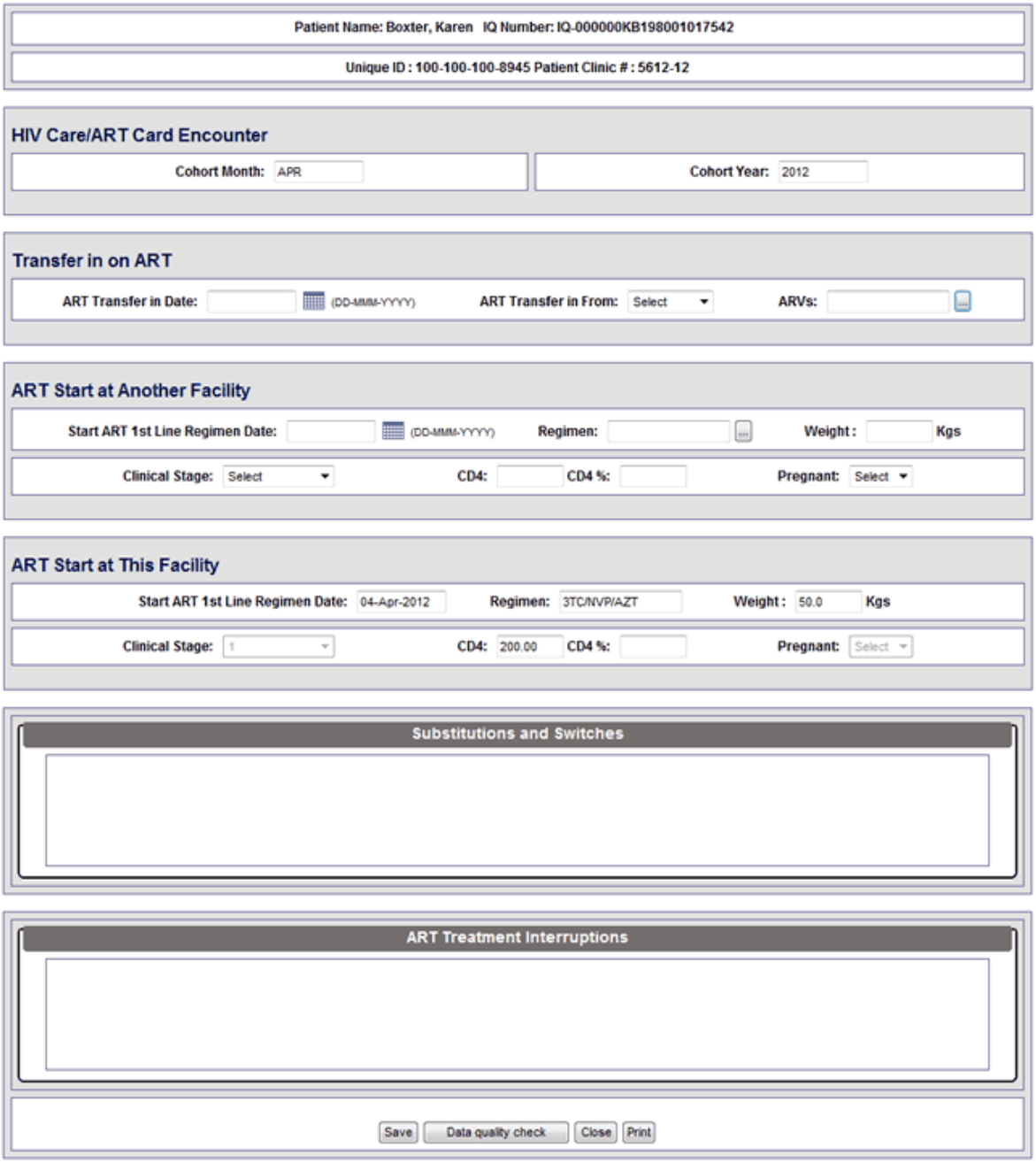
10.3.2 ART Care

- The ART Care Form is an one-time form. There is only one instance of this form.
- Many fields in this form are auto populated based on inputs from the pharmacy or HIV Care/ART Encounter form.
- Areas auto populated are:
  - Cohort month/year fields
  - All of the fields in the ART Start at This Facility section
  - Substitutions and Switches
  - ART Treatment Interruptions
- See the data dictionary for the data field field types and business rules for this form.



10.3.3 HIV Care/ART Encounter

- This is a multi-visit form. There can be more than one instance of the form for a patient. The form is driven by the visit date.
- The form had hide/display logic built in for optimal data entry and ease of use.
- See the data dictionary for the data field field types and business rules for this form.

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HIV Care/ART Encounter Form

Patient Name: Boxter, Karen IQ Number: IQ-000000KB198001017542

Unique ID : 100-100-100-8945 Patient Clinic # : 5612-12

*Visit Date: (DD-MMM-YYYY) If Scheduled:

Alternate Pick up Name:

Alternate Pick up Contact:

Follow up Date: (DD-MMM-YYYY)

Duration Since: ART Start Months Starting Current Regimen Months

Clinical Status

Weight: kg

Height: 200.0 cm

Pregnant: Yes No

Family Planning: Select

TB Status: Select

Potential Side Effects:

- Rash
- Peripheral Neuropathy
- Headache
- Stevens Johnson Syndrome
- Lipoatrophy/Lipodystrophy
- Insomnia

New OIs, Other Problems:

- Pulmonary TB
- Pulmonary TB Smear+
- Extrapulmonary TB
- PCP
- Pneumonia
- Other Mycobacteria

WAB Stage: Select

WHO Stage: Select

Pharmacy

Prescribe Drugs

CPT: Adhere: Select

ARV Drugs: Adhere: Select Why Poor/Fair Select

*Subsitutions/Interruption: Select

Investigations

Order Lab Tests

Referrals and Consultations

Referred To:

- PMTCT
- HBC
- PLHA Support Group/Club
- Orphan and vulnerable children group
- Medical specialty
- Nutritional support

# of Days Hospitalized:

Nutritional Support: Select

Infant Feeding Practice: Select

Attending Clinician: Select

Save Data quality check Close Print

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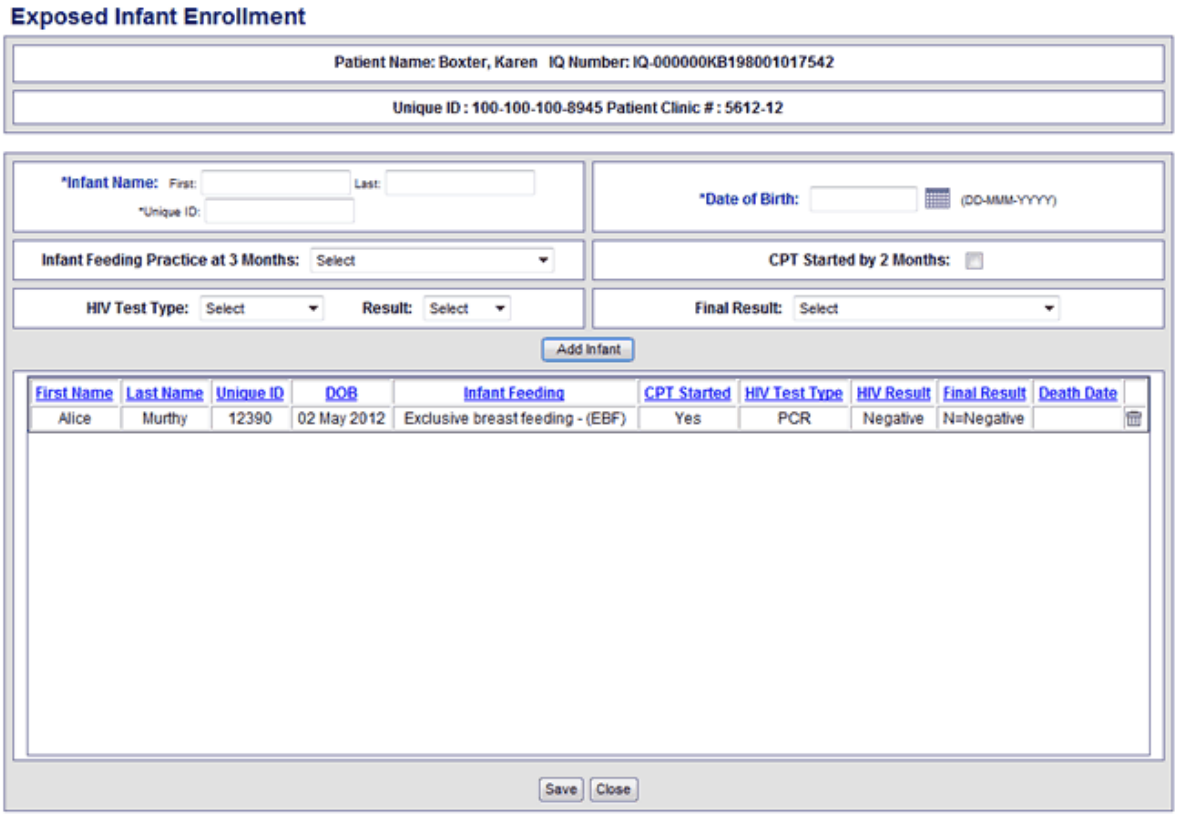
10.3.4 Exposed Infant Follow up

- This is a multi-entry form but with a grid display. Unlike the HIV ART Encounter, it is not driven by a visit date.
- You enter the data in the fields above the grid and click Add Infant. The fields display in the grid. Repeat adding children. When complete click the Save button to save all of the data.
- See the data dictionary for the data field field types and business rules for this form.
-


Exposed Infant Enrollment
Patient Name: Boxter, Karen IQ Number: IQ-000000KB198001017542
Unique ID : 100-100-100-8945 Patient Clinic # : 5612-12
*Infant Name: First: Last:
*Unique ID:
*Date of Birth: (DD-MMM-YYYY)
Infant Feeding Practice at 3 Months: Select
CPT Started by 2 Months:
HIV Test Type: Select
Result: Select
Final Result: Select
Add Infant
First Name Last Name Unique ID DOB Infant Feeding CPT Started HIV Test Type HIV Result Final Result Death Date
Alice Murthy 12390 02 May 2012 Exclusive breast feeding - (EBF) Yes PCR Negative N=Negative
Save
Close

10.4 Kenya MOH Clinical Forms

Kenya's health care system comprises Ministry of Health (MOH) and parastatals (state-owned organizations) organizations and the private sector, which includes private for-profit, NGO, and FBO facilities. The system is structured in 6 levels such that complicated medical cases are referred to a higher level. The structure thus consists:

Level 1: ***National referral hospitals*** are at the apex of the health care system, providing sophisticated diagnostic, therapeutic, and rehabilitative services.
Level 2: ***Provincial hospitals*** act as referral hospitals to their district hospitals. They also provide very specialized care.
Level 3: ***District hospitals*** concentrate on the delivery of health care services.
Level 4: ***Sub-district hospitals and nursing homes*** are similar but generally smaller than district hospital
Level 5: ***Health centers*** provide ambulatory, preventative health and curative health services
Level 6: ***Dispensaries*** are generally the system's first line of contact with patients, but in some areas, health centers or even hospitals are effectively the first points of contact.

The Ministry of Health provided clinical registers and forms for a wide variety of health areas such as

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HIV Care, Maternal and Child health, Nutrition, Cancer and so on. IQCare provides a series a forms that capture clinical patient indicators as per these forms.

Instructions and reference materials for all of the forms available in IQCare can be found at the Kenya Ministry of Health's site

10.4.1 ANC Register MOH 405

Purpose

The ANC Register serves as a summary of key events or services provided to a woman during her pregnancy. These services include promotional and preventive, nutritional support, and detection and treatment of any complications.

When and Who Completes the Form

The antenatal register is first completed upon contact with the patient at her initial visit to the clinic (booking day) and a new record/ form is opened on every subsequent visit to the clinic.The form is completed by the nurses or any other staff assigned the responsibility.

Fill in a New ANC Register MOH 405 Form

The active technical area should be ANC antenatal and postnatal clinic

1. From the Patient Home Page, click on the Create New Form link and select the ANC Register MOH 405 form.
2. Fill in the form, making sure you fill in the required fields. Note that some of the fields will be auto populated.
3. Click Save
4. IQCare displays a message alerting you of any required fields not filled in
5. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update an ANC Register 405 Form

1. To access a previously filled ANC Register MOH 405 form click on View Existing Forms and find the ANC Register MOH 405 form you want to update and click the link
2. Update the form
3. Click Save

Example Form

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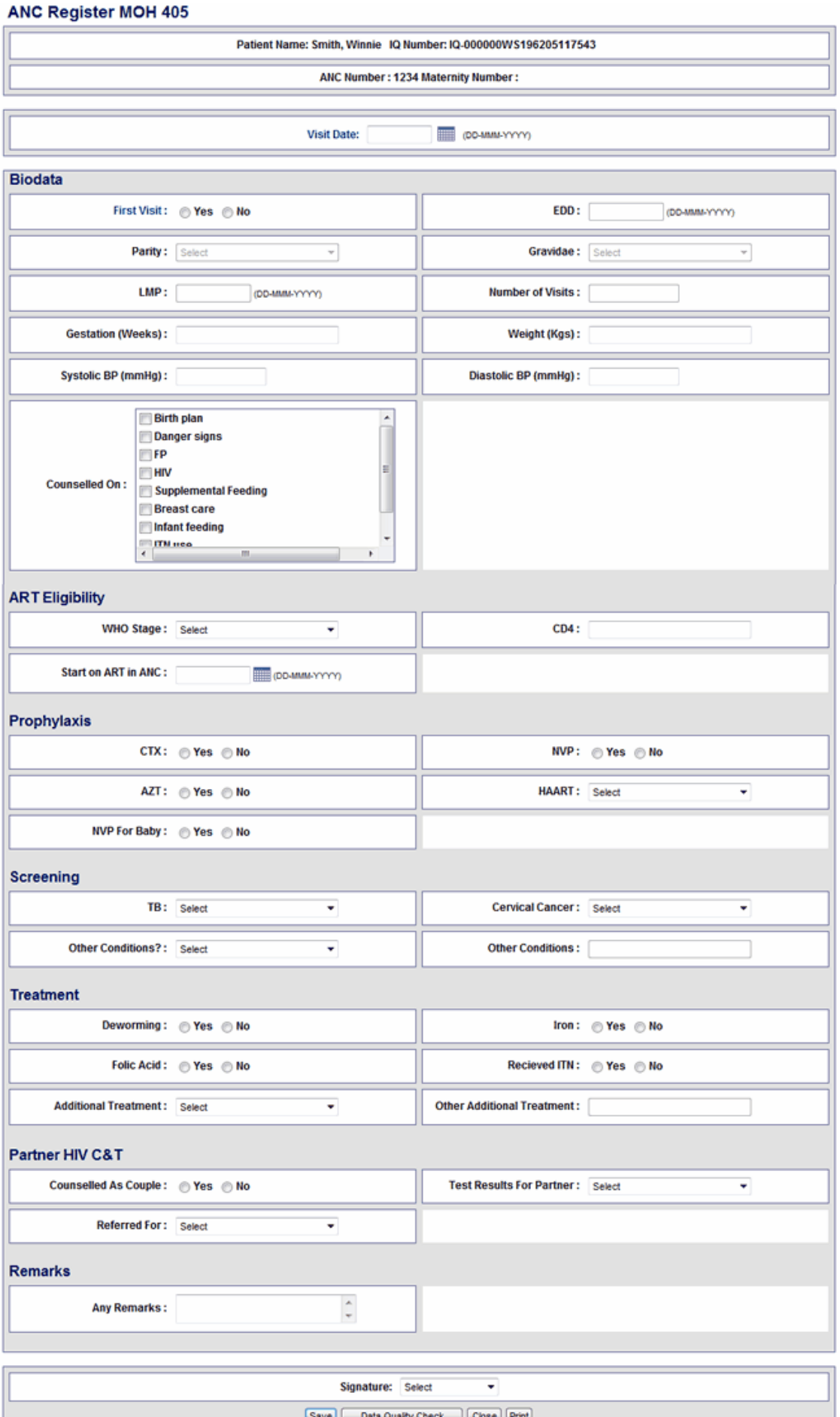
ANC Register MOH 405
Patient Name: Smith, Winnie IQ Number: IQ-000000WS196205117543
ANC Number : 1234 Maternity Number :
Visit Date: (DD-MMM-YYYY)
Biodata
First Visit : Yes No
EDD : (DD-MMM-YYYY)
Parity : Select
Gravidae : Select
LMP : (DD-MMM-YYYY)
Number of Visits :
Gestation (Weeks) :
Weight (Kgs) :
Systolic BP (mmHg) :
Diastolic BP (mmHg) :
Counselled On :
Birth plan
Danger signs
FP
HIV
Supplemental Feeding
Breast care
Infant feeding
ART Eligibility
WHO Stage : Select
CD4 :
Start on ART in ANC : (DD-MMM-YYYY)
Prophylaxis
CTX : Yes No
NVP : Yes No
AZT : Yes No
HAART : Select
NVP For Baby : Yes No
Screening
TB : Select
Cervical Cancer : Select
Other Conditions? : Select
Other Conditions :
Treatment
Deworming : Yes No
Iron : Yes No
Folic Acid : Yes No
Recieved ITN : Yes No
Additional Treatment : Select
Other Additional Treatment :
Partner HIV C&T
Counselled As Couple : Yes No
Test Results For Partner : Select
Referred For : Select
Remarks
Any Remarks :
Signature: Select

▼ **Data Dictionary**

Antenatal Care Register (MOH 405)								
Form/ Registration	**FieldName (no spaces)**	**Labeled (In the form)**	**Predefined field / existing**	**Options/list/ units**	**Nature of the field**	**Associated fields**	**Required Field (Yes/ No)**	**Data Quality Check (Yes/ No)**
Patient Details	1stVisit	1st Visit	Yes		Yes/No	If Yes, parity, Gravidae, LMP and EDD recorded. If "No", number of visits is filled	Yes	No
Patient Details	Parity	Parity	Yes		Numeric		No	
Patient Details	Gravidae	Gravidae	Yes		Numeric		No	
Patient Details	LMP	Date of Last Menstral Period	Yes		Date		No	No
Patient Details	EDD	Expected Date of Delivery	Yes		Date		No	No
Patient Details	Gestation	Gestation in Weeks	Yes		Numeric		No	No
Patient Details	Weight(KG)	Weight(KG)	Yes		Decimal Text Box		No	No
Patient Details	SystolicBP	SystolicBP	No		Numeric			
Patient Details	DiastolicBP	DiastolicBP	No		Numeric		No	No
Patient Details	Counselled On	Counselled On	Yes	Birth Plan, Danger signs,FP, HIV, Supplemental feeding, Breast Care, Infant Feeding, ITN, Other	Multi Select List		No	No

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				(Specify)				
Laboratory	Hg	Haemoglobin		Use Lab Form	Text		No	No
Laboratory	RPR_VDRL	RPR/VDRL		Use Lab Form	Select List		No	Yes
Laboratory	HIVResultInitial	HIV Result Initial		Use Lab Form	Select List		Yes	Yes
Laboratory	HIVResultRetest	HIV Result Retest		Use Lab Form	Select List		No	Yes
ART Eligibility	WHO	WHO Stage	No	I,II,III,IV	Select List		No	No
ART Eligibility	CD4	CD4	No		Decimal Text Box		No	Yes
ART Eligibility	ARTANCtDate	Start on ART in ANC	No		Date		No	No
Prophylaxis	CTX	CTX	No		Yes/No		No	
Prophylaxis	NVPMother	NVP	No		Yes/No		No	
Prophylaxis	AZTMother	AZT	No		Yes/No		No	
Prophylaxis	HAART	HAART	No	P=HAART for Prophylaxis, T=HAART for Treatment	Select List		No	
Prophylaxis	NVPforBaby	NVP for Baby	Yes		Yes/No		No	
Screened For	TB	TB	Yes	NO signs, TB suspected, TB Rx, ND, REF	Select List		No	
Screened For	CervicalCancer	Cervical Cancer	No	PAP, VIA	Select List		No	
Screened For	OtherConditions	Other Conditions	Yes	1=Hypertension, 2=Diabetes, 3=Epilepsy, 4=Malaria in Pregnancy, 5=STIs/RTI, 6=Others (Specify)	Multi Select List		No	
Treatment	Deworming	Deworming	No	Yes, No	Select List		No	No
Treatment	IPT1-3	IPT1-3	Yes	1,2,3,N/A	Select List		No	No

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Treatment	TTDose	TT Dose	Yes	1,2,3,4,5	Select List		No	No
Treatment	Iron	Iron	Yes	Yes, No	Select List		No	No
Treatment	FolicAcid	Folic Acid	Yes	Yes, No	Select List		No	No
Treatment	ReceivedITN	Received ITN	Yes	Yes, No	Select List		No	No
Treatment	AdditionalTreatment	Additional Treatment	Yes	1=Hypertension, 2=Diabetes, 3=Epilepsy, 4=Malaria in Pregnancy, 5=STIs/RTI, 6=Others (Specify)	Multi Select List		No	No
Partner HIV C&T	CounselledAsCouple	Counselled as a Couple	No	Yes, No	Select List	Marital Status	No	No
Partner HIV C&T	TestResultPartner	Test Result of Partner	Yes	P, N, U, KP	Select List		No	No
Referred For	ReferredFor	Referred For	No		Text Single Line		No	No
Remarks	Remarks	Remarks	No		Text Single Line		No	No

10.4.2 Maternity Register MOH 333

Purpose

The Maternity Register provides information on the following:

1. Delivery process and outcome
2. Laboratory tests
3. HIV prophylaxis to mother and baby and partner involvement

Who and When Completed

At the time a woman is admitted in labour ward until discharge. The records are filled by the nurses in the labour ward

Fill in a New Maternity Register

The active technical area should be ANC antenatal and postnatal clinic

1. From the Patient Home Page, click on the Create New Form link and select the maternity register
2. Fill in the form, making sure you fill in the required fields. Note that some of the fields will be auto populated.
3. Click Save
4. IQCare displays a message alerting you of any required fields not filled in
5. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

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Update a Maternity Register

1. To access a previously filled maternity register click on View Existing Forms and find the maternity register you want to update and click the link
2. Update the form
3. Click Save

Example Form

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Maternity Register MOH 333

Patient Name: Too, Dee IQ Number: IQ-000000DT200104057542

ANC Number : 0779 Maternity Number : 0987

Visit Date: (DD-MMM-YYYY)

Bio Data

Parity : Select

Gravidae : Select

LMP : (DD-MMM-YYYY)

EDD : (DD-MMM-YYYY)

Maternity Diagnosis

Diagnosis :
- APH
- PPH
- Eclampsia
- Ruptured Uterus
- Obstructed Labour
- Sepsis
- Other

Other Maternity Diagnosis :

Delivery

Duration Of Labour (Hrs) :

Date Of Delivery : (DD-MMM-YYYY)

Gestation At Birth :

Mode Of Delivery : Select

Placenta Complete : Yes No

Blood Loss (mls) :

Condition After Delivery : Select

Other Delivery Complications :

Baby 1

Time Of Delivery Baby One :

Gender Baby One : Select

Birth Weight Baby One :

Live Birth, FSB,MSB Baby One : Select

APGAR Score Baby One : Select

Baby 2

Time Of Delivery Baby Two :

Gender Baby Two : Select

Birth Weight Baby Two :

Live Birth, FSB,MSB Baby Two : Select

APGAR Score Baby Two : Select

Baby 3

Time Of Delivery Baby Three :

Gender Baby Three : Select

Birth Weight Baby Three :

Live Birth, FSB, MSB Baby Three : Select

APGAR Score Baby Three : Select

HIV Status

HIV Status ANC : Select

HIV Status Maternity : Select

RPR Test Results : Select

ARV Prophylaxis

ANC Regimen : Select

Maternity ART Regimen : Select

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Data Dictionary

Maternity Register MOH 333							
Form/ Registration	**Field Name (no spaces)**	**Labeled (In the form)**	**Options/ list/units**	**Nature of the field**	**Associated fields**	**Required Field (Yes/ No)**	**Data Quality Check (Yes/ No)**
Maternity Register	AdmissionNumber	Admission Number		Text Single line		Yes	Yes
Maternity Register	AdmissionDate	Date of admission		Date	Admission Number	Yes	Yes
Maternity Register	NoOfANCVisits	No Of ANC Visits		Text Single line		No	No
Maternity Register	FullNames	Full Names		Text Single line		Yes	Yes
Maternity Register	Village/Estate	Village / Estate		Text Single line		Yes	Yes
Maternity Register	Age	Age		Numeric	DOB		
Maternity Register	MaritalStatus	Marital Status	Married, divorced; widowed; Separated; single	Select list		No	Yes
Bio Data							
Maternity Register	Parity	Parity		Numeric		No	No
Maternity Register	Gravidae	Gravidae		Numeric		No	No
Maternity Register	LMP	Date of last menstrual period		Date		Yes	Yes
Maternity Register	EDD	Expected Date of Delivery		Date		Yes	Yes
Maternity Diagnosis							
Maternity Register	Diagnosis	Diagnosis		Multi Text line		No	No
Maternity Register	OtherMaternityDiagnosis	Other Maternity Diagnosis		Multi Text line	Diagnosis	No	No
Delivery							
Maternity Register	DurationOfLabour	Duration of Labuor		Numeric		No	No
Maternity Register	DateOfDelivery	Date Of Delivery		Date		Yes	Yes
Maternity Register	PlacentaComplete	Placenta Complete		Yes, No		Yes	Yes

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Maternity Register MOH 333							
Maternity Register	DeliveryMode	Mode Of Delivery	Normal Delivery, Ceaserian Section, Breech, Assisted Vaginal, Separated	Select list		Yes	Yes
Maternity Register	GestationATBirth	Gestation at Birth		Numeric		Yes	Yes
Maternity Register	BloodLoss	Blood loss		Numeric		No	No
Maternity Register	ConditionAfterDelivery	Condition After Delivery	Alive, Dead	Select list		Yes	Yes
Maternity Register	OtherDeliveryComplications	Other Delivery Complications					
Baby 1							
Maternity Register	TimeOfDeliveryBabyOne	Time of Delivery Baby One		Text Single line		No	No
Maternity Register	GenderBabyOne	Gender Baby One	Male, Female	Select list		Yes	Yes
Maternity Register	BirthWeightBabyOne	Birth Weight in grammes Baby One		Numeric		Yes	Yes
Maternity Register	LiveBirthBabyOne	Live Birth Baby One	FSB, MSB	Select list		Yes	Yes
Maternity Register	APGARScoreBabyOne	APGAR Score Baby One		Select list			
Baby 2							
Maternity Register	TimeOfDeliveryBabyTwo	Time of Delivery Baby Two		Text Single line		No	No
Maternity Register	GenderBabyTwo	Gender Baby Two	Male, Female	Select list		Yes	Yes
Maternity Register	BirthWeightBabyTwo	Birth Weight in grammes Baby Two		Numeric		Yes	Yes
Maternity Register	LiveBirthBabyTwo	Live Birth Baby Two	FSB, MSB	Select list		Yes	Yes
Maternity Register	APGARScoreBabyTwo	APGAR Score Baby Two		Select list			
Baby 3							
Maternity Register	TimeOfDeliveryBabyTwo	Time of Delivery Baby Two		Text Single line		No	No
Maternity Register	GenderBabyTwo	Gender Baby Two	Male, Female	Select list		Yes	Yes
Maternity	BirthWeightB	Birth Weight in grammes		Numeric		Yes	Yes

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Maternity Register MOH 333							
Register	abyTwo	Baby Two					
Maternity Register	LiveBirthBabyTwo	Live Birth Baby Two	FSB, MSB	Select list		Yes	Yes
Maternity Register	APGARScoreBabyTwo	APGAR Score Baby Two		Select list			
HIV Status							
Maternity Register	ANCHIVStatus	ANC HIV Status	Positive, Negative, Confirmed Positive, Unknown	Select list		Yes	Yes
Maternity Register	HIVStatusMaternity	HIV Status at Maternity	Positive, Negative, Unknown	Select list		Yes	Yes
Maternity Register	RPRResults	RPR Results	Positive, Negative	Select list		No	No
ARV Prophylaxis To Mother							
Maternity Register	ANC	Regimen Issued to mother at ANC		Select list		No	No
Maternity Register	Maternity	Regimen Issued to mother in Maternity		Select list		No	No
Maternity Register	NVPToBaby	NVP issued To Baby		Yes, No		No	No
ARV Prophylaxis To Baby							
Maternity Register	ProphylaxisIssuedToBaby	ARV Prophylaxis issued to Baby	NVP, AZT, 3TC, HAART	Select list		No	No
Maternity Register	CTXIssuedToMother	Mother Issued with CTX	SdNVP, NVP, AZT, 3TC, HAART	Yes, No		No	No
Maternity Register	VitaminAIssued	Vitamin A		Yes, No		No	No
Partner Involvement							
Maternity Register	PartnerTested	Partner Tested		Yes, No		Yes	Yes
Maternity Register	PartnersHIVTestResult	HIV Test Result	Positive, Negative, Confirmed Positive, Unknown	Select list		Yes	No
Birth Notification & Discharge							

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Maternity Register MOH 333							
Maternity Register	BirthNotificationNumber	Birth Notification Number		Text Single line		No	No
Maternity Register	DischargeDate	Date of Discharge		Date		Yes	No
Maternity Register	StatusOfBaby	Status of Baby at Discharge	Alive, Dead	Select list	DischargeDate	Yes	Yes
Maternity Register	Comments	Comments		Multi Text line		No	No

10.4.3 HIV Exposed Infant Follow up Card

Introduction

The HIV Exposed Infant (HEI) card has four (4) parts:

1. The front page (which summarizes patients details, key events before and after enrollment);
2. Replicated details from the child health cards (where similar details as on the mother/child's booklet are recorded);
3. Routine care and assessment (covering growth monitoring, prophylaxis and treatment)
4. Assessments for child development and TB infection.

Purpose

To serve as a detailed record of care for HIV exposed infants and facilitate follow up of the child until discontinuation – arising from testing HIV positive, confirmed negative, death, or dropping out for any reason than the foregoing.

Fill in a New HEI follow up card

The active technical area should be ANC antenatal and postnatal clinic

1. From the Patient Home Page, click on the Create New Form link and select the HEI follow up card
2. Fill in the form, making sure you fill in the required fields. Note that some of the fields will be auto populated.
3. Click Save
4. IQCare displays a message alerting you of any required fields not filled
5. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update HEI follow up Card

1. To access a previously filled HEI form click on View Existing Forms and find the HEI follow up card you want to update and click the link
2. Update the form
3. Click Save

Example of HEI Card - Part I

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HEI Follow Up Card

Patient Name: Moseti, David IQ Number: IQ-000000DM201202157541

ANC Number : 7777 Maternity Number : 8737h0

Visit Date: (DD-MMM-YYYY)

Infant Profile

Birth Weight (Kgs) :

Source of Referral : Paediatric, OPD, Maternity, CCC, MCH/PMTCT, Other Specify

Specify other source of referral :

ARV Prophylaxis : Select

Specify Other PEP Regimen :

History of TB Contact in Household : Yes No

Parent Profile

Name of Mother :

Alive? : Select

Mother Received Drugs For PMTCT? : Yes No

If Yes Select Drug Combination : Sd NVP Only, AZT+NVP+3TC, Interrupted HAART, HAART, Other Specify

Specify Other PMTCT Regimen :

On ART At Enrolment Of Infant? : Yes No

CCC Where Mother Accesses Care :

Mode Of Delivery : Select

Place Of Delivery : Select

Immunisation History

Immunisation Received By Child : BCG, OPV at Birth, OPV/Penta 1, OPV/Penta 2, OPV/Penta 3, Measles 6 months, Measles 9 months, Pneumococcal

Specify Other Immunisation :

Laboratory Information

Date Of First PCR : (DD-MMM-YYYY)

Result Of First PCR : Select

First PCR DBS Sample Code :

Date Of Repeat PCR (for rejections) : (DD-MMM-YYYY)

Result Of Repeat PCR : Select

Repeat PCR DBS Sample Code :

Date Of First AntiBody Test : (DD-MMM-YYYY)

Result Of First AntiBody Test : Select

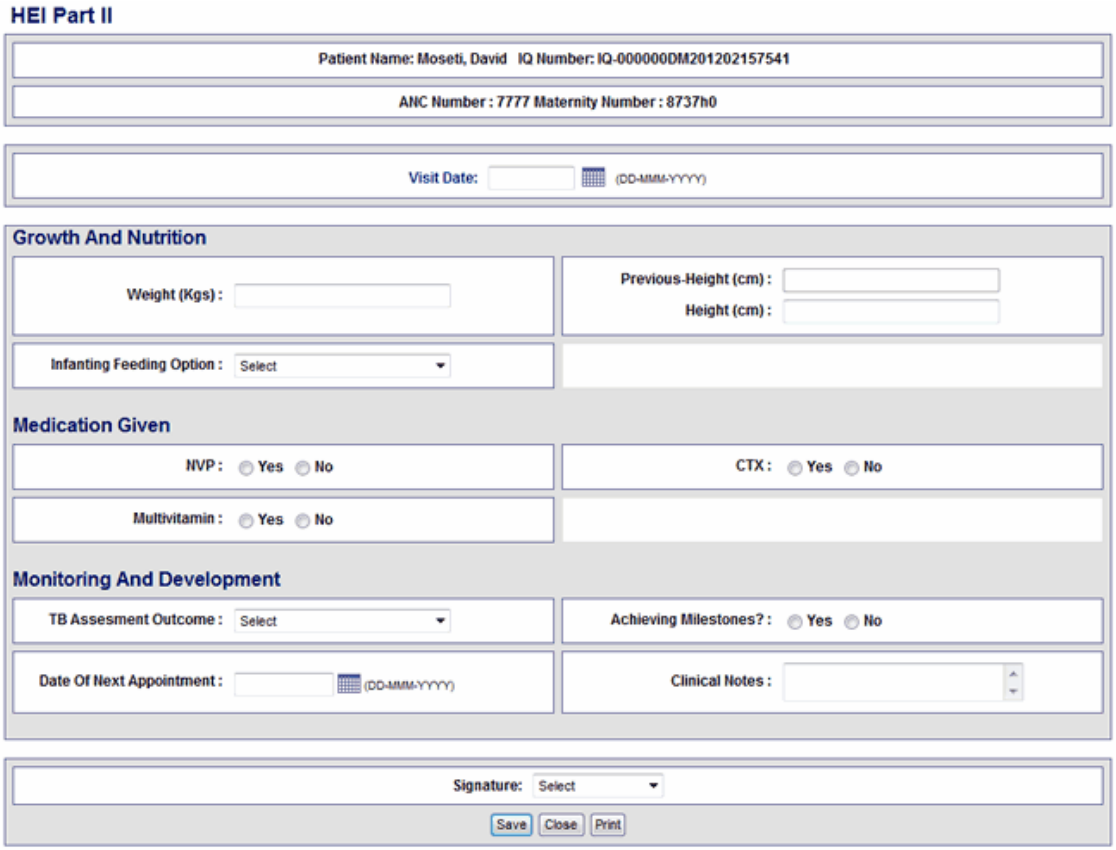
Date Of Confirmatory PCR Test : (DD-MMM-YYYY)

Result Of Confirmatory PCR Test : Select

Confirmatory PCR Sample

Date Of Repeat Confirmatory

Example of HEI Card - Part II


HEI Part II
Patient Name: Moseti, David IQ Number: IQ-000000DM201202157541
ANC Number : 7777 Maternity Number : 8737h0
Visit Date: (DD-MMM-YYYY)
Growth And Nutrition
Weight (Kgs) :
Previous Height (cm) :
Height (cm) :
Infanting Feeding Option : Select
Medication Given
NVP : Yes No
CTX : Yes No
Multivitamin : Yes No
Monitoring And Development
TB Assesment Outcome : Select
Achieving Milestones? : Yes No
Date Of Next Appointment : (DD-MMM-YYYY)
Clinical Notes :
Signature: Select
Save Close Print

Example of HEI Card - Part III

This is a combination of the HEI and the maternal History

Data Dictionary

HEI Infant Follow up card							
Form/ Registration	**FieldName (no spaces)**	**Labelled (In the form)**	**Options/list/ units**	**Nature of the field**	**Associated fields**	**Required Field (Yes/ No)**	**Data Quality Check (Yes/ No)**
Infant Profile							
HEI Infant Follow up card	HEIIDNo	HEI ID Number		Text Single line		Yes	Yes
HEI Infant Follow up card	ChildsName	Name		Text Single line		Yes	Yes
HEI Infant Follow up card	GenderOfChild	Sex	Male, Female	Select list		Yes	Yes
HEI Infant Follow up card	DOB	Date Of Birth		Date		Yes	Yes
HEI Infant	BirthWeight	Birth Wt (Kg)		Decimal Text		Yes	Yes

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Follow up card				Box			
HEI Infant Follow up card	EnrollmentDate	Date Of Enrollment		Date		Yes	Yes
HEI Infant Follow up card	EnrollmentAge	Age at Enrollment		Numeric		No	No
HEI Infant Follow up card	ChildRefferdFrom	Source of Referral	Paediatric, OPD, Maternity, CCC, MCH/PMTCT, Other Specify	Select list		No	No
HEI Infant Follow up card	OtherChildReferalSource	Other Specify		Text Single line	ChildReferalSource	No	No
HEI Infant Follow up card	ChildPEPARVs	ARV Prophylaxis	SdNVP Only, SdNVP+AZT+3TC, NVP for 6 weeks (mother on HAART or not BF), NVP during BF, None	Select list		No	No
HEI Infant Follow up card	OtherPEP	Specify other PEP Dispensed		Text Single line		No	NO
HEI Infant Follow up card	ContactTB	History of TB Contact in household		Yes, No		No	No
Parent Profile							
HEI Infant Follow up card	MothersName	Name of mother		Text Single line		No	No
HEI Infant Follow up card	StateOfMother	Alive?		Alive, Dead		No	No
HEI Infant Follow up card	MotherRefferdToARV	Mother Received Drugs for PMTCT?		Yes, No		No	No
HEI Infant Follow up card	PMTCTRegimen	If Yes Select Drug Combination	SdNVP, Interrupted HAART, AZT+NVP+3TC, HAART Specify.	Select list		No	No
HEI Infant Follow up card	OtherPMTCTRegimen	Specify other PMTCT Regimen		Text Single line		No	No
HEI Infant Follow up card	OnART	On ART at Enrollment of Infant?		Yes, No		No	No
HEI Infant Follow up card	MothersPointOfCare	CCC where PMTCT was dispensed		Text Single line		No	No
HEI Infant Follow up card	DeliveryMode	Mode Of Delivery	SVD, C-Section	Select list		No	No
HEI Infant Follow up card	DeliveryLocation	Place Of Delivery	Facility, Home	Select list		No	No
Immunisation History							
HEI Infant Follow up card	Immunisation	Immunisation received by Child	BCG, OPV at Birth, OPV/Penta 1, OPV/Penta 2, OPV/Penta 3, Measles at 6	Multi Select list		No	No

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			mnths, Measles at 9 mnths, Other Specify				
HEI Infant Follow up card	OtherImmunisation	Specify other immunisation		Text Single line	Immunisation	No	No
Laboratory Information							
HEI Infant Follow up card	FirstPCRDate	Date of First PCR		Date		No	No
HEI Infant Follow up card	FirstPCRResults	Results of First PCR	Positive, Negative, Sample Rejected	Select list		No	No
HEI Infant Follow up card	FirstPCRSampleCode	First PCR DBS Sample Code		Text Single line		No	No
HEI Infant Follow up card	RepeatPCRDate	Repeat PCR Date (For rejections)		Date		No	No
HEI Infant Follow up card	RepeatPCRResults	Results of repeat PCR	Positive, Negative, Sample Rejected	Select list		No	No
HEI Infant Follow up card	RepeatPCRSampleCode	Repeat PCR DBS Sample Code		Text Single line		No	No
HEI Infant Follow up card	FirstAntiBodyTestDate	Date of First Antibody Test		Date		No	No
HEI Infant Follow up card	FirstAntiBodyTestResult	Result of First Antibody Test	Positive, Negative, Indeterminate	Select list		No	No
HEI Infant Follow up card	ConfirmatoryPCRDate	Date of Confirmatory PCR		Date		No	No
HEI Infant Follow up card	ConfirmatoryPCRResult	Results of Confirmatory PCR	Positive, Negative, Sample Rejected	Select list		No	No
HEI Infant Follow up card	ConfirmatoryPCRSampleCode	DBS Sample Code for Confirmatory PCR		Text Single line		No	No
HEI Infant Follow up card	RepeatConfirmatoryPCRDate	Date Confirmatory PCR Date		Date		No	No
HEI Infant Follow up card	RepeatConfirmatoryPCRResult	Results for Repeat Confirmatory PCR	Positive, Negative, Sample Rejected	Select list		No	No
HEI Infant Follow up card	RepeatConfirmatoryPCRSampleCode	DBS Sample Code for Repeat Confirmatory PCR		Text Single line		No	No
HEI Infant Follow up card	FinalAntibodyTestDate	Date of Final Antibody Test		Date		No	No
HEI Infant Follow up card	FinalAntibodyResults	Results of Final Antibody Test	Positive, Negative, Indeterminate	Select list		No	No
Patient Locator Address One							

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HEI Infant Follow up card	Address1	Address 1	Current, Permanent	Select list		No	No
HEI Infant Follow up card	RelationshipAddress1	Relationship Address 1	Parent, Guardian, Other Specify	Select list		No	No
HEI Infant Follow up card	OtherrelationshipAddress1	Specify Other relationship Address 1		Text Single line		No	No
HEI Infant Follow up card	ContactName1	Name contact 1		Text Single line		No	No
HEI Infant Follow up card	PhoneContact1	Phone Contact 1		Numeric		No	No
HEI Infant Follow up card	DistrictContact1	District Contact 1		Text Single line		No	No
HEI Infant Follow up card	EstateVillage1	Estate / Village Contact 1		Text Single line		No	No
HEI Infant Follow up card	HouseNumber Contact1	House Number Contact 1		Text Single line		No	No
HEI Infant Follow up card	ChiefContact1	Sub / Chiefs Name Contact 1		Text Single line		No	No
HEI Infant Follow up card	LandmarkContact1	Landmark Contact 1		Text Single line		No	No
Patient Locator Address Two							
HEI Infant Follow up card	Address2	Address 2	Current, Permanent	Select list		No	No
HEI Infant Follow up card	RelationshipAddress2	Relationship Address 2	Parent, Guardian, Other Specify	Select list		No	No
HEI Infant Follow up card	OtherrelationshipAddress2	Specify Other relationship Address 2		Text Single line		No	No
HEI Infant Follow up card	ContactName2	Name contact 2		Text Single line		No	No
HEI Infant Follow up card	PhoneContact2	Phone Contact 2		Numeric		No	No
HEI Infant Follow up card	DistrictContact2	District Contact 2		Text Single line		No	No
HEI Infant Follow up card	EstateVillage2	Estate / Village Contact 2		Text Single line		No	No
HEI Infant Follow up card	HouseNumber Contact2	House Number Contact 2		Text Single line		No	No
HEI Infant Follow up card	ChiefContact2	Sub / Chiefs Name Contact 2		Text Single line		No	No
HEI Infant Follow up card	LandmarkContact2	Landmark Contact 2		Text Single line		No	No

10.4.4 Maternal & Exposed Infant Registers

Purpose

When and Who Completes the Form

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Fill in a New Maternal and Exposed Infant Register Form

The active technical area should be ANC Maternity and Post Natal

1. From the Patient Home Page, click on the Create New Form link and select either Maternal and Exposed Infant I, II or III form
2. Fill in the form, making sure you fill in the required fields. Note that some of the fields will be auto populated.
3. Click Save
4. IQCare displays a message alerting you of any required fields not filled in
5. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update a Maternal and Exposed Infant Register Form

1. To access a previously filled Maternal and Exposed Infant I, II or III form click on View Existing Forms and find the form you want to update and click the link
2. Update the form
3. Click Save

Maternal and Exposed Infant I Example

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Maternal and Exposed Infant I

Patient Name: Too, Dee IQ Number: IQ-000000DT200104057542

ANC Number : 0779 Maternity Number : 0987

Maternal Section

Mother's Name :

LMP : (DD-MMM-YYYY)

EDD : (DD-MMM-YYYY)

Maternal HIV History

No prior ARV Exposure :

Current ART :

Current ART Date : (DD-MMM-YYYY)

Single Dose NVP :

Single Dose NVP Date : (DD-MMM-YYYY)

Previous Regimen :

Months on RX :

Lowest CD4 :

Lowest CD4 Date : (DD-MMM-YYYY)

Most Recent CD4 :

Most Recent CD4 Date : (DD-MMM-YYYY)

Current CD4 :

Current CD4 Date : (DD-MMM-YYYY)

Highest Viral Load :

Highest Viral Load date : (DD-MMM-YYYY)

Current Viral Load :

Current Viral Load Date : (DD-MMM-YYYY)

Interpartum And Infant Feeding Plan

ARVs Prescribed Antenatally For Use Intrapartum : Select

Antenatal Plan For Prophylaxis During Breast Feeding : Select

Antenatal Planned Option For Infant Feeding : Select

Labor, Delivery, And Postpartum History

Date of delivery/Abortion/Miscarriage : (DD-MMM-YYYY)

Birth Weight (Kgs) :

Mode Of Delivery : Select

Infant Status : Select

Place Of Delivery : Select

Facility Name :

Maternal Intra-Partum ARV : Select

Postnatal Individual Infant Feeding Counseling (AFASS score) :

AFASS Score Date : (DD-MMM-YYYY)

ARVs Prescribed For Use Postpartum : Select

Postnatal Planned Option For Infant Prophylaxis : Select

Postnatal Planned Option For Infant Feeding : Select

Referrals And Maternal Outcomes

Maternal HIV Care : Select

Maternal HIV Care Date : (DD-MMM-YYYY)

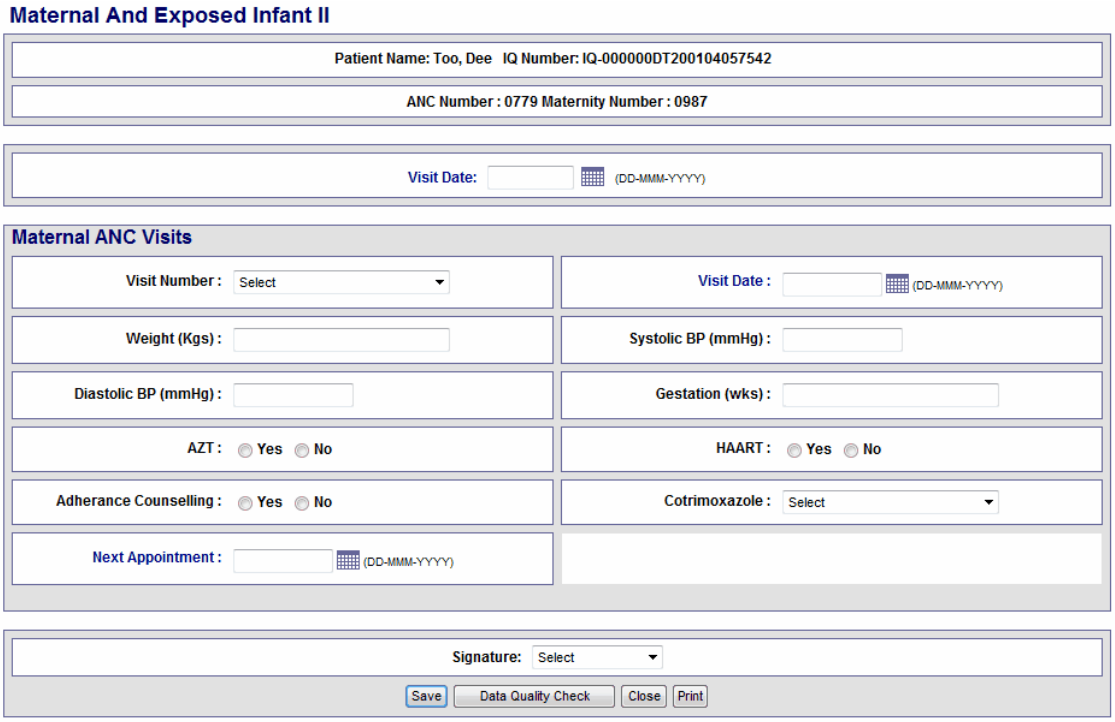
FP & RH Services : Select

FP & RH Services Date : (DD-MMM-YYYY)

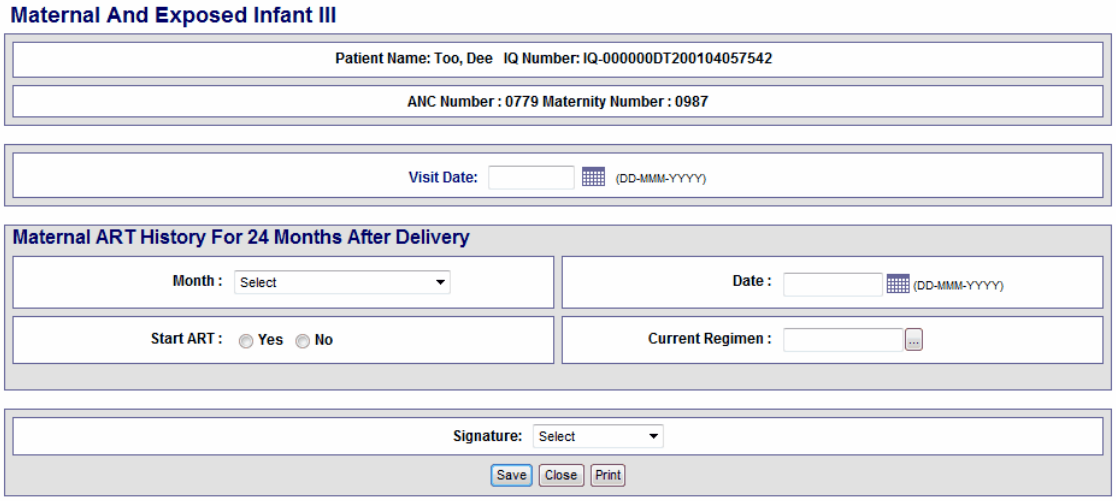
Signature: Select

Save | Data Quality Check | Close | Print

Maternal and Exposed Infant II Example



Maternal and Exposed Infant III Example



Data Dictionaries

Maternal and Exposed Infant Form I						
Form/ Registration	FieldName (no spaces)	Labeled (In the form)	Predefined field / existing	Options /list/ units	Nature of the field	Required Field (Yes/

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Maternal and Exposed Infant Form I						
						No)
Maternal Section	MothersName	Mother's Name	Yes		Text Single Line	Yes
Maternal Section	LMP	LMP	Yes		Date	No
Maternal Section	EDD	EDD	Yes		Date	No
Maternal HIV History	NoPriorARVExposure	No Prior ARV Exposure	No		Checkbox	
Maternal HIV History	CurrentART	Current ARV	No		Regimen	
Maternal HIV History	CurrentARTDate	Current ART Date	No		Date	
Maternal HIV History	SingleDoseNVP	Single Dose NVP	No		Checkbox	
Maternal HIV History	SingleDoseNVPDate	Single Dose NVP Date	No		Date	
Maternal HIV History	PreviousRegimen	Previous Regimen	No		Regimen	
Maternal HIV History	PreviousRegimenMonthsOnRx	Months On Rx	No		Text Single Line	
Maternal HIV History	LowestCD4	Lowest CD4	No		DecimalTextBox	
Maternal HIV History	LowestCD4Date	Lowest CD4 Date	No		Date	
Maternal HIV History	MostRecentCD4	MostRecentCD4	No		DecimalTextBox	
	MostRecentCD4Date	Most Recent CD4 Date	No		Date	
Maternal HIV History	CurrentCD4	Current CD4	No		DecimalTextBox	
Maternal HIV History	CurrentCD4Date	Current CD4 Date	No		Date	
Maternal HIV History	HighestViralLoad	Highest Viral Load	No		DecimalTextBox	
Maternal HIV History	HighestViralLoadDate	Highest Viral Load Date	No		Date	
Maternal HIV History	CurrentViralLoad	Current Viral Load	No		DecimalTextBox	
Maternal HIV History	CurrentViralLoadDate	Current Viral Load Date	No		Date	

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Maternal and Exposed Infant Form I						
Interpartum And Infant Feeding	ARVsPrescribedAntenatallyforIntrapartum	ARVsPrescribedAntenatallyforIntrapartum	No	AZT, 3TC, AZT/3TC, NVP	Select List	
Interpartum And Infant Feeding	Antenatal Planned option for infant feeding	Antenatal Plan For Prophylaxis During Breast Feeding	No	Exclusive Breast Feeding, Exclusive Replacement Feeding	Select List	
Interpartum And Infant Feeding	FeedingOption	Antenatal Planned Option For Infant Feeding	No	Exclusive Breast Feeding-(EBF), Replacement feeding -(EBMS), Mixed feeding (MF), Other, Exclusive Substitute Feeding	Select List	
Labour, Delivery AND Postpartum History	DeliveryAbortionMiscarriageDate	Date Of Delivery Abortion/ Miscarriage	No		Date	
Labour, Delivery AND Postpartum History	BirthWeight	Birth Weight (Kgs)	No		DecimalTextBox	
Labour, Delivery AND Postpartum History	ModeofDelivery	Mode of Delivery	No	Normal Delivery, Caeserian Section, Breech, Assisted Vaginal, Separated	Select List	

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Maternal and Exposed Infant Form I						
Labour, Delivery AND Postpartum History	InfantStatus	Infant Status	No	Live Birth, Still Birth, Neonatal Death	Select List	
Labour, Delivery AND Postpartum History	PlaceofDelivery	Place of Delivery	No	Home, Hospital	Select List	
Labour, Delivery AND Postpartum History	MaternalIntraPartumARV	Maternal Intra-Partum ARV	No	None, AZT/3TC/ SdNVP, SD NVP only, HAART	Select List	
Labour, Delivery AND Postpartum History	AFASSScore	Postnatal Individual Infant Feeding Counseling (AFASS score)	No		Numeric	
Labour, Delivery AND Postpartum History	AFASSScoreDate	AFASS Score Date	No		Date	
Labour, Delivery AND Postpartum History	ARVsPrescribedforUsePostpartum	ARVs Prescribed for Use Postpartum	No	None, AZT/3TC/ SdNVP, SD NVP only, HAART	Select List	
Labour, Delivery AND Postpartum History	PostnatalPlanned OptionalInfant prophylaxis	Postnatal Planned Optional Infant Prophylaxis	No	None, Continuous Maternal ART, Maternal ART until cessation of BF, Daily infant NVP	Select List	

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Maternal and Exposed Infant Form I						
Labour, Delivery AND Postpartum History	PostnatalFeeding Options	Postnatal Feeding Options	No	Exclusive Breast Feeding, Exclusive Replace ment Feeding	Select List	
Referrals And Maternal Outcomes	MaternalHIVCare Referral	Maternal HIV Care Referral	No	Referred , Attendan ce Confirme d	Select List	
Referrals And Maternal Outcomes	MaternalHIVCare ReferralDate	Maternal HIV Care Referral Date	No		Date	
Referrals And Maternal Outcomes	FPandRHServices Referral	FP and RH Services Referral	No	Referred , Attendan ce Confirme d	Select List	
Referrals And Maternal Outcomes	FPandRHServices ReferralDate	FP and RH Services Referral Date	No		Date	

Maternal and Exposed Infant Form II					
Form/ Registration	**Field Name (no spaces)**	**Labeled (In the form)**	**Predefin ed field / existing**	**Options/ list/units**	**Nature of the field**
Section Name:					
Maternal ANC Visits	VisitNo	Visit Number	No	1, 2, 3, 4, 5, 6, 7, 8	Select List
Maternal ANC Visits	VisitDate	Visit Date	No		Date
Maternal ANC Visits	Weight	Weight (Kgs)	Yes		DecimalTe xtBox
Maternal ANC Visits	SystolicBP	Systolic BP (mmHg)	No		Numeric
Maternal ANC Visits	DiastolicBP	Diastolic BP (mmHg)	No		Numeric
Maternal ANC Visits	Gestation(wks)	Gestation (wks)	Yes		DecimalTe xtBox
Maternal ANC Visits	AZT	AZT	No		Yes/No

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Maternal and Exposed Infant Form II					
Maternal ANC Visits	HAART2	HAART	No		Yes/No
Maternal ANC Visits	AdherenceCounselling	Adherence Counselling	No		Yes/No
Maternal ANC Visits	Cotrimoxazole	Cotrimoxazole	No	Yes, No	Select List
Maternal ANC Visits	NextAppointmentDate	Next Appointment	No		Date

Maternal and Exposed Infant Form II					
Form/Registration	**FieldName (no spaces)**	**Labelled (In the form)**	**Predefined field / existing**	**Options/list/ units**	**Nature of the field**
Section Name:					
	MothersName	Mother's Name	Yes		Text Single Line
Maternal ART History For 24 Months After Delivery	MaternalARTHistoryMonth	Month	No	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24	Select List
Maternal ART History For 24 Months After Delivery	MaternalARTHistoryDate	Date	No		Date
Maternal ART History For 24 Months After Delivery	StartART	Start ART	No		Yes/No
Maternal ART History For 24 Months After Delivery	CurrentRegimen	Current Regimen	No		Regimen

10.4.5 Post Natal Register MOH 406

Introduction

The postnatal register is used to record information concerning a woman's health immediately following delivery. The postnatal period lasts for a period of 6 weeks following delivery.

Purpose

The Post Natal register serves as a tool for recording information and services provided to the client in the postnatal period including:

- Support to the woman to return to the pre-pregnant state,
- Assessing and identifying danger signs, education to the woman on own care and care of the infant.
- A number of services provided are recorded here including HIV testing, infant feeding options,

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family planning and ARV prophylaxis etc.

Fill in a New Postnatal Register

The active technical area should be ANC antenatal and postnatal clinic

1. From the Patient Home Page, click on the Create New Form link and select the postnatal register
2. Fill in the form, making sure you fill in the required fields. Note that some of the fields will be auto populated.
3. Click Save
4. IQCare displays a message alerting you of any required fields not filled in
5. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update a Postnatal Register

1. To access a previously filled Postnatal register click on View Existing Forms and find the Postnatal register you want to update and click the link
2. Update the form
3. Click Save

Example Form

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Postnatal Register MOH 406

Patient Name: Too, Dee IQ Number: IQ-000000DT200104057542

ANC Number : 0779 Maternity Number : 0987

Visit Date: (DD-MMM-YYYY)

Maternity History

Date Of Delivery : (DD-MMM-YYYY)

Place Of Delivery : Select

Mode Of Delivery : Select

State Of Baby : Select

Vital Signs

Temperature (deg C) :

Pulse (bpm) :

Systolic BP (mmHg) :

Diastolic BP (mmHg) :

Postnatal Examinations

Parlor : Select

Breast : Select

Uterus :

PPH : Yes No

C Section Site : Select

Lochial : Select

Episiotomy :
- Repaired
- Gaping
- Infected
- Healed
- Not Documented

HIV Status

Prior Known Status : Select

Tested In PNC <= 72 hours : Select

Tested In PNC > 72 hours : Select

Prophylaxis

NVP To Baby : Yes No

CTX To Baby : Yes No

CTX To Mother : Yes No

Partner HIV C&T

Couple Counselled? : Yes No

Partner Tested In PNC : Select

Results : Select

Screening, FP and Treatment

Screened For Cervical Cancer? : Select

Provided With Modern FP Method :
- Condom
- Emergency contraceptive pills
- Oral contraceptive pills
- Injectable
- Implant
- IUD
- LAM
- Diaphram/Cervical cap

Multi-Vitamin : Yes No

Haematinics : Yes No

Referred : Select

Remarks

Data Dictionary

Post Natal Register MOH 406							
Form/ Registration	**FieldName (no spaces)**	**Labeled (In the form)**	**Options/ list/units**	**Nature of the field**	**Associated fields**	**Required Field (Yes/ No)**	Data Quality Check (Yes/No)
Post Natal Register	**VisitDate**	**Date of visit**		**Date**		**Yes**	Yes
Post Natal Register	PNCNo	PNC Register Number		Text Single line		Yes	Yes
Post Natal Register	Admission Number	Admission Number		Text Single line		Yes	Yes
Post Natal Register	FullNames	Full Names		Text Single line		Yes	Yes
Post Natal Register	Village/ Estate	Village / Estate		Text Single line		Yes	Yes
Post Natal Register	Age	Age		Numeric	DOB	Yes	Yes
Maternity History							
Post Natal Register	DeliveryDate	Date of Delivery		Date		Yes	Yes
Post Natal Register	PlaceOfDelivery	Place of Delivery		Text Single line		Yes	Yes
Post Natal Register	DeliveryMode	Mode of Delivery	Normal Delivery, Ceaserian Section, Breech, Assisted Vaginal, Separated	Select list		Yes	Yes
Post Natal Register	StateOfBaby	State of Baby	Alive, Dead	Select list		Yes	Yes
Vital Signs							
Post Natal Register	Temperature	Temperature		Decimal Text Box		Yes	Yes
Post Natal Register	Pulse	Pulse		Decimal Text Box		Yes	Yes
Post Natal Register	SystolicBP	Systolic BP		Numeric		Yes	Yes
Post Natal Register	DiastolicBP	Diastolic BP		Numeric			
Post Natal Examinations							
Post Natal Register	Parlor	Parlor	Mild, Moderate, Severe	Select list		Yes	Yes

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Post Natal Register MOH 406							
Post Natal Register	Breast	Breast	Normal, Crappled Nipple, Engorged, Mastistis	Select list		Yes	Yes
Post Natal Register	Uterus	Uterus		Text Single line		Yes	Yes
Post Natal Register	PPH	PPH		Yes, No		Yes	Yes
Post Natal Register	C-SectionSite	C -Section site	Bleeding, Normal, Infected	Select list		Yes	Yes
Post Natal Register	Lochial	Lochial	Normal, Foul Smelling Excessive	Select list		Yes	Yes
Post Natal Register	Episiotomy	Episiotomy	Repaired, Gaping, Infected, Healed	Select list		Yes	Yes
HIV Status							
Post Natal Register	PriorKnownStatus	Prior Known Status	Positive, Negative, Unknown	Select list		Yes	Yes
Post Natal Register	TestedInPNC<=72Hours	Tested in PNC <=72 Hours.	Positive, Negative, Not Done, Not Applicable	Select list		Yes	Yes
Post Natal Register	TestedInPNC>72Hours	Tested in PNC > 72 Hours.	Positive, Negative, Not Done, Not Applicable	Select list		Yes	Yes
Prophylaxis							
Post Natal Register	NVPtoBaby	Baby issued with NVP		Yes,No		Yes	No
Post Natal Register	CTXtoBaby	Baby issued with CTX		Yes,No		Yes	No
Post Natal Register	CTXtoMother	Mother issued with CTX		Yes,No		Yes	No
Partner HIV C&T							
Post Natal Register	CoupleCounselled	Couple Counselled		Yes,No		Yes	No
Post Natal Register	PartnerTestedInPNC	Partner Tested In PNC	Yes, No, N/A	Select list		Yes	No

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Post Natal Register MOH 406							
Post Natal Register	Results	Test Results	Positive, Negative, Unknown, Confirmed Positive	Select list		Yes	Yes
Post Natal Register	CervicalCancerScreened	Screening for Cervical Cancer	PAP = Pap Smear Used,VIA = VIA Method Us	Select list		Yes	No
Post Natal Register	ProvidedWithFPMethod	Provided with Modern FP Method	C = Condoms, LAM = Lactational Amenorrhea Method, ECP = Emergency contraceptive pills, D = Diaphragm/cervical cap, OC = Oral contraceptive pills, FA = Fertility awareness method/ periodic abstinence, INJ = Injectable, TL = Tubal ligation/ female sterilization, IMP = Implant, V = Vasectomy (partner's), IUD =	Select list		Yes	No

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Post Natal Register MOH 406							
			Intrauterine device.				
Treatment							
Post Natal Register	MultiVitamins	MultiVitamins		Yes, No		Yes	No
Post Natal Register	Haematenics	Haematenics		Yes, No		Yes	No
Post Natal Register	Reffered	Reffered	VCT, OutPatient,Other Source, PMTCT, TB Outpatient, InPatient, Other Facility, Child Welfare Clinic	Multi Select list		Yes	No
Post Natal Register	Remarks	Remarks		Multi Text list		No	No

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10.4.6 HIV/ART Care Card (Kenya)

Introduction

The card has three parts:

1. The face (which summarizes key events, before and after enrollment into care)
2. The encounter pages (where information about each visit is recorded
3. The education and counseling page

Purpose

The HIV Care/ART Card serves as a detailed record of clinical diagnosis and treatment. Any member of the clinical team who sees the patient needs to be able to know key clinical details and what education and support the patient has been given on the previous visits, in order to know what to do on this visit. This card also serves as a transfer document and the basis of continuity of care. This is done by photocopying or scanning a copy in order to send it together with other transfer documents.

When Completed

The card is opened immediately when a patient registers for chronic HIV care including ART treatment and the card is updated on each visit. The card therefore should be kept at the facility. Initial visit details cover demographics, patient's source and ART history. The remaining sections of the card can then be updated on subsequent visits by the clinician.

Note

Do not open this card for patients who are yet not confirmed HIV positive. This includes those on PEP and HIV exposed infants; instead, a different card is opened for HIV exposed infants and is only transferred onto this card upon a confirmed HIV positive result.

Who Completes

At first visit, depending on the set up of the CCC and staffing levels, a doctor, clinical officer, nurse, health records officer or data clerk fills this form and on subsequent visits filled by a doctor, clinical officer or nurse.

Fill in a New HIV/ART Card Form

The active technical area should be HIV Care ART Card KE

1. From the Patient Home Page, click on the Create New Form link and select the Enrollment Details, Initial Assessment Form or ART Visit form
2. Fill in the form, making sure you fill in the required fields. Note that some of the fields will be auto populated.
3. Click Save
4. IQCare displays a message alerting you of any required fields not filled in
5. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update a Postnatal Register

1. To access a previously filled HIV Care ART Card form click on View Existing Forms and find the HIV/ART Card register you want to update and click the link
2. Update the form
3. Click Save

Enrollment Details Form Example

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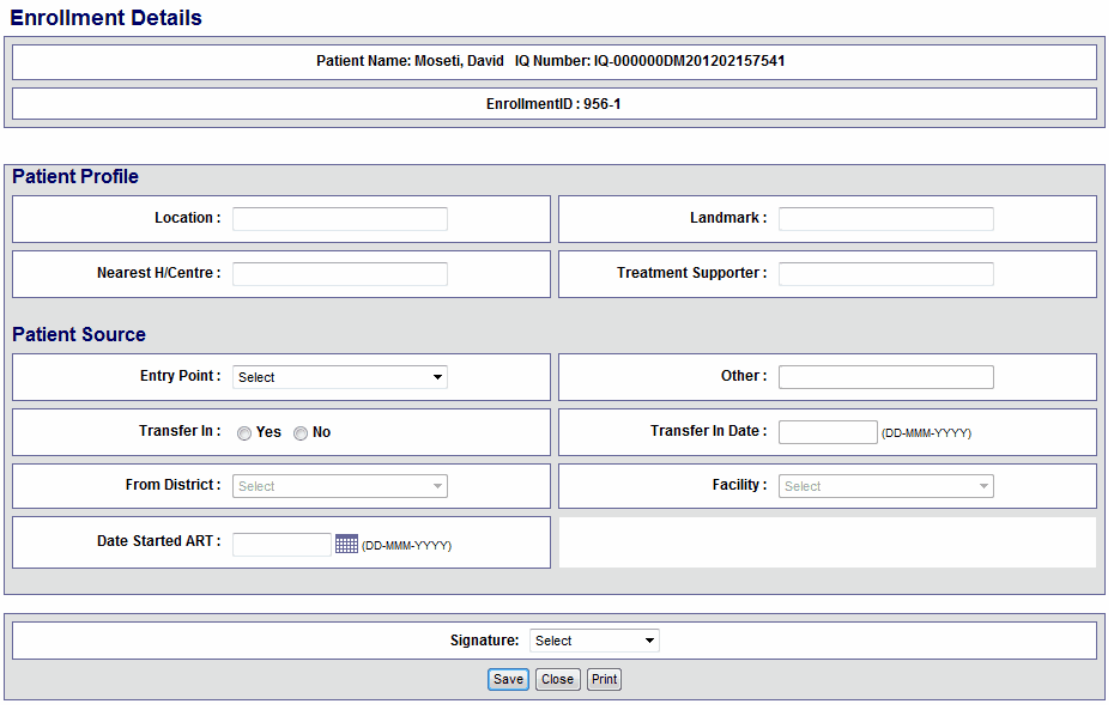

Initial Assessment Form Example

Initial Assessment Form

Patient Name: Moseti, David IQ Number: IQ-000000DM201202157541

EnrollmentID : 956-1

ART History

Child Accompanied By Caregiver : ◯ Yes ◯ No	If yes, (Specify relationship) : Select
Pregnant? : Yes ◯ No	LMP : (DD-MMM-YYYY)

Presenting Complaint(s):

Cough : ☐	Cough Duration (Days) :
Headache : ☐	Headache Duration (Days) :
Pain Swallowing : ☐	Pain Swallowing Duration (Days) :
General Malaise : ☐	General Malaise Duration (Days) :
Runny Nose : ☐	Runny Nose Duration (Days) :
Fever : ☐	Fever Duration (Days) :
Nausea : ☐	Nausea Duration (Days) :
Skin/Hair/Nail : ☐	Skin/Hair/Nail Duration (Days) :
Ear Pain : ☐	Ear Pain Duration (Days) :
Convulsions : ☐	Convulsions Duration (Days) :
Oral Sores : ☐	Oral Sores Duration (Days) :
Poor Vision : ☐	Poor Vision Duration (Days) :
Eye Itch : ☐	Eye Itch Duration (Days) :
Altered Gait : ☐	Altered Gait Duration (Days) :
Abdominal Pains : ☐	Abdominal Pains Duration (Days) :
Parotid Swelling : ☐	Parotid Swelling Duration (Days) :
Redness Pain : ☐	Redness Pain Duration (Days) :
Dizziness : ☐	Dizziness Duration (Days) :
Diarrhoea : ☐	Diarrhoea Duration (Days) :
Genital Urinary Sore Discharge : ☐	Genital Urinary Sore/Discharge/ Pain duration (Days) :
Numbness/Tingling : ☐	Numbness/Tingling Duration (Days) :

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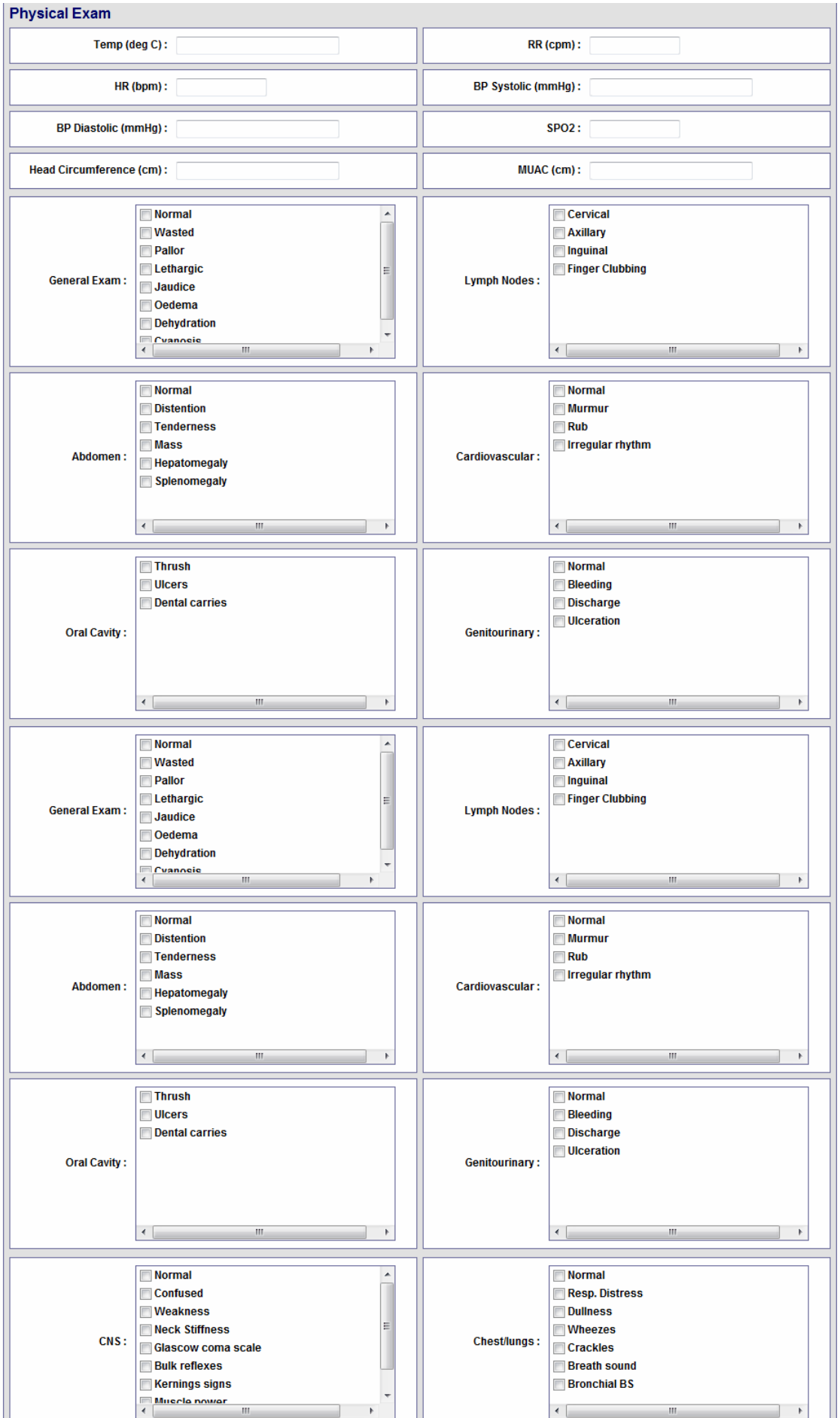
Physical Exam
Temp (deg C) :
RR (cpm) :
HR (bpm) :
BP Systolic (mmHg) :
BP Diastolic (mmHg) :
SPO2 :
Head Circumference (cm) :
MUAC (cm) :
General Exam :
Normal
Wasted
Pallor
Lethargic
Jaudice
Oedema
Dehydration
Cyanosis
Lymph Nodes :
Cervical
Axillary
Inguinal
Finger Clubbing
Abdomen :
Normal
Distention
Tenderness
Mass
Hepatomegaly
Splenomegaly
Cardiovascular :
Normal
Murmur
Rub
Irregular rhythm
Oral Cavity :
Thrush
Ulcers
Dental carries
Genitourinary :
Normal
Bleeding
Discharge
Ulceration
General Exam :
Normal
Wasted
Pallor
Lethargic
Jaudice
Oedema
Dehydration
Cyanosis
Lymph Nodes :
Cervical
Axillary
Inguinal
Finger Clubbing
Abdomen :
Normal
Distention
Tenderness
Mass
Hepatomegaly
Splenomegaly
Cardiovascular :
Normal
Murmur
Rub
Irregular rhythm
Oral Cavity :
Thrush
Ulcers
Dental carries
Genitourinary :
Normal
Bleeding
Discharge
Ulceration
CNS :
Normal
Confused
Weakness
Neck Stiffness
Glascow coma scale
Bulk reflexes
Kernings signs
Muscle power
Chest/lungs :
Normal
Resp. Distress
Dullness
Wheezes
Crackles
Breath sound
Bronchial BS

ART Visit Form Example

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ART Visit

Patient Name: Moseti, David IQ Number: IQ-000000DM201202157541

EnrollmentID : 956-1

Visit Date: (DD-MMM-YYYY)

Clinical Status

Visit Type : Select

Weight (Kgs) :

Systolic BP (mmHg) :

Diastolic BP (mmHg) :

Previous-Height (cm) :

Height (cm) :

Pregnancy : Yes No

Family Planing

Family Planning Status : Select

Family planning Method :
- Condoms
- Emergency Contraceptive Pills Dispensed
- Oral Contraceptive Pills
- Injectible
- Implant
- Intrauteran device
- Lactational Amenorhea
- Diaphram/Cervical cap

Reason Not on FP : Select

Want FP : Select

TB Status

TB Status : Select

TB Treatment Start Date : (DD-MMM-YYYY)

TB Registration Number :

Nutritional Support

Referral/Hospitalized : Select

Side Effects and Adherence

Potential Side Effects :
- Rash
- Peripheral Neuropathy
- Headache
- Stevens Johnson Syndrome
- Lipoatrophy/Lipodystrophy
- Insomnia
- Anemia
- Severe N&V

New OIs & Other Problems :
- Zoster
- Thrush - Oral/Vaginal
- Cough
- Difficult breathing
- Fever
- Dementia/Enceph
- Weight loss
- Pneumonia

WHO Stage : Select

ARV Adherence : Select

Why Poor ARV Adherence : Select

CTX Adherence : Select

Why Poor CTX Adherence : Select

ART Treatment Interruption Reason : Select

PwP

PwP : Yes No

PwP Services :
- Couple Counselling
- Targeted risk reduction
- Condom promotion/provision
- Needle and syringe programmes

- Discordant Couple
- MsM
- Intra Drug Users

Data Dictionary

Enrollment Form							
Section	**Field Name**	**Labeled**	**Nature of the field**	**Options/ list/units**	**Associated fields**	**Required Field**	**Data Quality Check**
Patient Profile	Location	Location	TextSingleLine				
Patient Profile	Landmark	Landmark	TextSingleLine				
Patient Profile	NearestHCentre	Nearest H/ Centre	TextSingleLine				
Patient Profile	MaritalStatus	Marital Status	Select List	Married polygamous Married monogamous Divorced Widowed Cohabitating Single			
Patient Profile	TreatmentSupporter	Treatment Supporter	TextSingleLine				
Patient Source	EntryPoint	Entry Point	Select List	PMTCT VCT IPD-Ad IPD-Che MCH-Child OPD Other			
Patient Source	OtherFacilityReferredFrom	Other (Specify e.g (STI)	TextSingleLine		Entry point - Other		
Patient Source	TransferIn	Transfer In	Yes/No	If Yes	ARTTransferInFrom TransferIn Date DateStartedART		
Patient Source	ARTTransferInDate	Transfer In Date	Date		TransferIn - Yes		
Patient Source	District	From District	Select List				
Patient Source	ARTTransferInFrom	Facility	Select List				
Patient Source	DateStartedART	Date Started ART	Date				

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ART Visit							
Section	**Field Name**	**Labeled**	**Nature of the field**	**Options/list/ units**	**Associated fields**	**Required Field**	**Data Quality Check**
	Visit Date	Visit Date	Date				
Clinical Status	VisitType	Visit Type	Select List	Scheduled Self Picked Pills			
Clinical Status	Weight	Weight (kg)					
Clinical Status	BP	Blood Pressure					
Clinical Status	Height	Height (cm)					
Clinical Status	Pregnancy	Pregnancy		Yes No	EDD ANC Recently Induced Abortion Date Recently Miscarriage Date		
Clinical Status	MiscarriageDate	Recently Miscarriaged Date	Date				
Clinical Status	AbortionDate	Recently Induced Abortion Date	Date				
Clinical Status	ANCNumber	ANC Number	TextSingle Line				
Clinical Status							
Clinical Status	EDD	Enter EDD	Date				
Family Planning	FamilyPlanningStatus	Family Planning Status	Select List	Currently on Family Planning Not on Family Planning Wants Family Planing	Family Planning Method ReasonNo FP Provided Referred		

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ART Visit							
Family Planning	Family Planning Method	Family planning Method	Select List	Condom Emergency Contraceptive Pills Dispensed Oral Contraceptive Pills Injectible Implant Intrauteran device Lactational Amenorhea Diaphram/ Cervical cap Fartility awareness/ Periodic abstenance Tubal Ligation/ Female sterilization Vasectomy (partner's) Undecided			
Family Planning	ReasonNoFP	Reason	Select List	Want to get pregnant Thinks cant get pregnant Not Sexually Active Now			
TB Status	TBStatus	TB Status	Select List	No Signs or Symptoms Suspect Not Done ***Currently on TB Treatment***	Month/ Year TB Reg No		
TB Status	TBRxStartDate	TB Treatment Start Date	Date				
TB Status	TB Reg No	TB Registration Number	DecimalText				
Nutritional Support	NutritionalSupport	Referral/ Hospitalized	Select List	Therapeutic Feeding Infant Feeding Counselling Food Support Infant Feeding Practice			
Side effects	ARV Side Effects	Potential Side Effects	Select List				

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ART Visit							
and Adherance							
Side effects and Adherance	New Ois, Other Medical Conditions	New Ols & Other Problems	Select List				
Side effects and Adherance	WHO Stage	WHO Stage	Select List	I ii iii iv N/A			
Side effects and Adherance	ARVAdherence	ARV Adherence	Select List	Good Fair Poor	WhyPoor ARVAdherence		
Side effects and Adherance	WhyPoorARVAdherence	Why poor/fair ARV Adherence	Select List	Toxicity/Side effects Share with others Forgot Felt Better Too ill Stigma, disclosure or privecy issue Drug stock out Patient lost/run out of pills Delivery/travel problems Inability to pay Alcohol Depression Pill Burden Other Specify			
Side effects and Adherance	CTXAdherence	CTX Adherence	Select List	Good Fair Poor	WhyPoor CTXAdherence		

ART Visit							
Side effects and Adherance	WhyPoorCTXAdherence	Why Poor/Fair CTX Adherence	Select List	Toxicity/Side effects Share with others Forgot Felt Better Too ill Stigma, disclosure or privacy issue Drug stock out Patient lost/run out of pills Delivery/travel problems Inability to pay Alcohol Depression Pill Burden Other Specify			
Side effects and Adherance	ARVWhy	ART Treatment Interruption Reason	Select List	Toxicity/Side Effects Pregnancy Due to New TB New Drug Available Drug Out of Stock Other Reason (Specify)			
Side effects and Adherance	ChangeReasonSpecify	Other Reason (Specify)	TextSingleLine				
PwP	PwP	PwP	Yes/No				
PwP	AtRiskPopulation	At Risk Population	MultiSelectList	Discordant Couple MsM Intra Drug Users Sex Worker Client to Sex Worker			
PwP	PWPServices	PWP Services	MultiSelectList				
Next Appointment		Date of Next Appointment	Date			Yes	

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10.4.7 Nutrition and HIV/AIDS Register

Purpose

The Nutrition and HIV/AIDS register serves as a record of key events or services provided to the clients on ARVs or on Care or for children exposed to HIV.
These services include nutrition assessment, counseling, support and referral.

When Completed

The Nutrition register is first completed upon contact with the patient at their initial and subsequent visits to the nutrition clinic.

Fill in a New Nutrition and HIVAIDs Register

The active technical area should be Nutrition

1. From the Patient Home Page, click on the Create New Form link and select the Nutrition and HIVAIDS register
2. Fill in the form, making sure you fill in the required fields. Note that some of the fields will be auto populated.
3. Click Save
4. IQCare displays a message alerting you of any required fields not filled in
5. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update a Nutrition and HIVAIDS Register

1. To access a previously filled Nutrition register click on View Existing Forms and find the Postnatal register you want to update and click the link
2. Update the form
3. Click Save

Example Form

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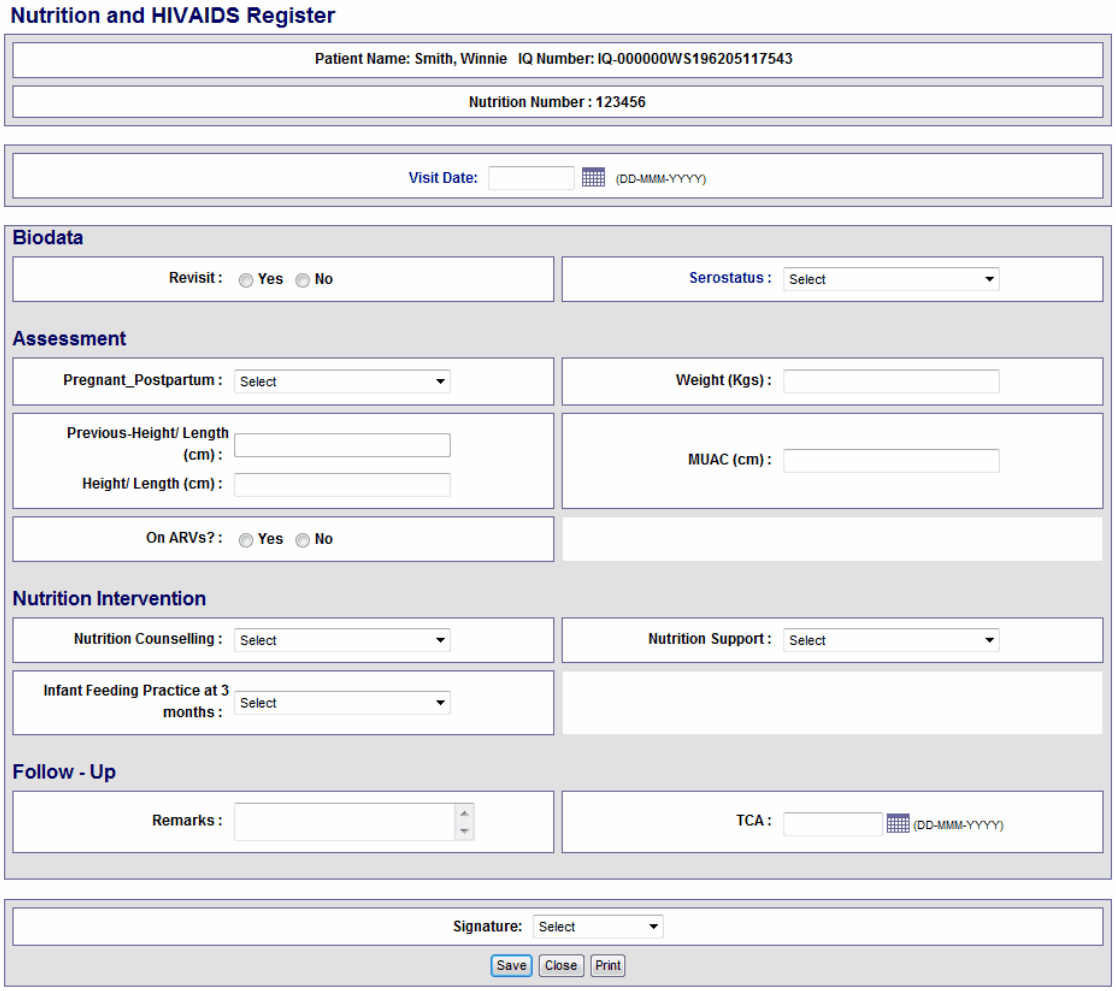

Data Dictionary

Nutrition and HIV/AIDS Register						
Form/ Registration	**FieldName (no spaces)**	**Labeled (In the form)**	**Options/list/ units**	**Nature of the field**	**Required Field (Yes/ No)**	**Data Quality Check (Yes/ No)**
Biodata	Revisit	Revisit	Yes,No	Yes,No	Yes	Yes
Biodata	Serostatus	Serostatus	P,N	P,N	Yes	Yes
Assessment	Pregnantpostpartum	Pregnant or Postpartum	P,PP	P,PP	Yes	Yes
Assessment	Weight	Wt (Kg)		Decimal text box		
Assessment	Height	HT (Cm)		Decimal text box	Yes	yes
Assessment	MUAC	MUAC(cm)		Decimal text box	Yes	Yes

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Nutrition and HIV/AIDS Register						
Assessment	OnARVs	On ARVs?	Y/N	Y,N	No	No
Nutritional Intervention	Nutritionalcounselling	Nutritional Counselling	Infant and young child feeding, Critical Nutrition Practices, IYCN+CNPs	Select List	No	No
Nutritional Intervention	Nutrionalsupport	Nutritional support	Therapeutic feeding, supplementary feeding, Multiple Micronutrients	Select List	No	No
Nutritional Intervention	FeedindPractice	Feeding Practice at 3 months	Exclusive breastfeeding EBF, Replacement Feeding EBMS, Mixed Feeding MF, Exclusive Substitute Feeding, Other	Select List	No	No
Follow-Up	Remarks	Remarks		Text single line	No	No
Follow-Up	TCA	Date of appointment		Date	Yes	Yes

10.4.8 HIV Testing & Counseling Lab MOH 362

Purpose

This register is designed for service providers to record their daily practice of HIV testing and counseling (HTC) services using rapid HIV test kits. The register captures necessary information on HTC related variables. This information will be used to monitor and evaluate HTC service program at all levels. It is also useful for self and facility evaluation.

This register can be used in two ways as follows depending on what works well for each facility

- Per service delivery point e.g. particular counseling room
- Per service provider (individual HTC provider)

Fill in a New HTC Lab MOH 362

The active technical area should be Nutrition

1. From the Patient Home Page, click on the Create New Form link and select the HTC Lab MOH 362
2. Fill in the form, making sure you fill in the required fields. Note that some of the fields will be auto populated.
3. Click Save
4. IQCare displays a message alerting you of any required fields not filled in

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5. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update a HTC Lab MOH 362

1. To access a previously filled HTC Lab MOH register click on View Existing Forms and find the HTC Lab MOH register you want to update and click the link
2. Update the form
3. Click Save

Example Form

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Data Dictionary

Register - MOH 362 HTC Lab							
Form/ Registration	FieldName (no spaces)	Labeled (In the form)	Options/list/units	Nature of the field	Associated fields	Required Field (Yes/	Data Quality Che

Register - MOH 362 HTC Lab							
						No)	ck (Yes/ No)
Testing Strategy	Strategy	Strategy	Regular HTC services- HP,HTC services for non patients - NP,Static HCT services in intergrated VCT-VI, Static HCT services in stand alone VCT VS, Home based HTC services - HB, Mobile and all other outreach VCT services - MO, O (Other)	Select List	OtherStrategy	Yes	
Testing Strategy	OtherStrategy	Other Strategy					
Testing Strategy	TestedBefore	Tested Before	Y, N	Yes/No	TestResults	Yes	
Testing Strategy	TestsResult	Test Results	N, P, DN, NA	Select List	testedbefore		
Testing Strategy	MonthLastTested	When last tested	1,2,3,4,5,6,7,8,9,10,11,12	Select List	testedbefore		
Testing Strategy	MARPS	MARPS	Not Applicable, Fisherman, Truck Driver, Sex Worker, Men having sex with other men, Prisoner, Intravenous Drug User IDU, Others	Select List	OtherMARPS	Yes	
Testing Strategy	OtherMARPS	Other MARPS		Text Single line	MARPS		
Testing Strategy	Disability	Disability	NA,D,B,M,P,O	Select List	None		
Testing Strategy	OtherDisability	Other Disability		Text Single line			
Testing Strategy	Consent	Consent	Yes, No	Yes/No	Disability	Yes	
Testing	CoupleTesting	Clent Tested as	Individual, Couple	Select List			
Testing	ResultsTest1	1st Test Result	P, N, I	Select List			
Testing	ResultsTest2	2nd Test Result	P, N, I	Select List			
Testing	ResultsTest3	3rd Test Result	P, N, I	Select List			
Results	FinalResult	Final Result	P, N, ID	Select List	resultstest1, resultest2,	Yes	Yes

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Register - MOH 362 HTC Lab							
					resulttest3		
Results	FinalResultsGiven	Final Result Given	Y, N	Yes/No	resultstest1, resulttest2, resulttest3	Yes	Yes
Results	CoupleDiscordant	Couple Discordant	Y, N, NA	Select List	coupletesting	Yes	Yes
Results	QCDBSCollected	Quality Control DBS Collected	Y, N	Yes/No	DBSResult		
Results	DBSResults	DBS Results	P, N,R	Select List			
TB	TBScreening	TB Screening	S, N, ND, T	Select List			
Referral	ReferredTo	Refer to		Text Single line	Test results		
Comments	Remarks	Remarks		Select List			

10.4.9 Cervical Cancer Case Finding

Purpose

Cervical Cancer Case finding form is used to track information about cervical cancer screening and re-screening of HIV positive women.

Fill in a New Cervical Cancer Case Finding Form

The active technical area should be Cervical Cancer Case Finding

1. From the Patient Home Page, click on the Create New Form link and select the Cervical Cancer Case Finding form
2. Fill in the form, making sure you fill in the required fields. Note that some of the fields will be auto populated.
3. Click Save
4. IQCare displays a message alerting you of any required fields not filled in
5. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update a Cervical Cancer Case Finding Form

1. To access a previously filled Cervical Cancer Case Finding register click on View Existing Forms and find the Cervical Cancer Case Finding you want to update and click the link
2. Update the form
3. Click Save

Example Form

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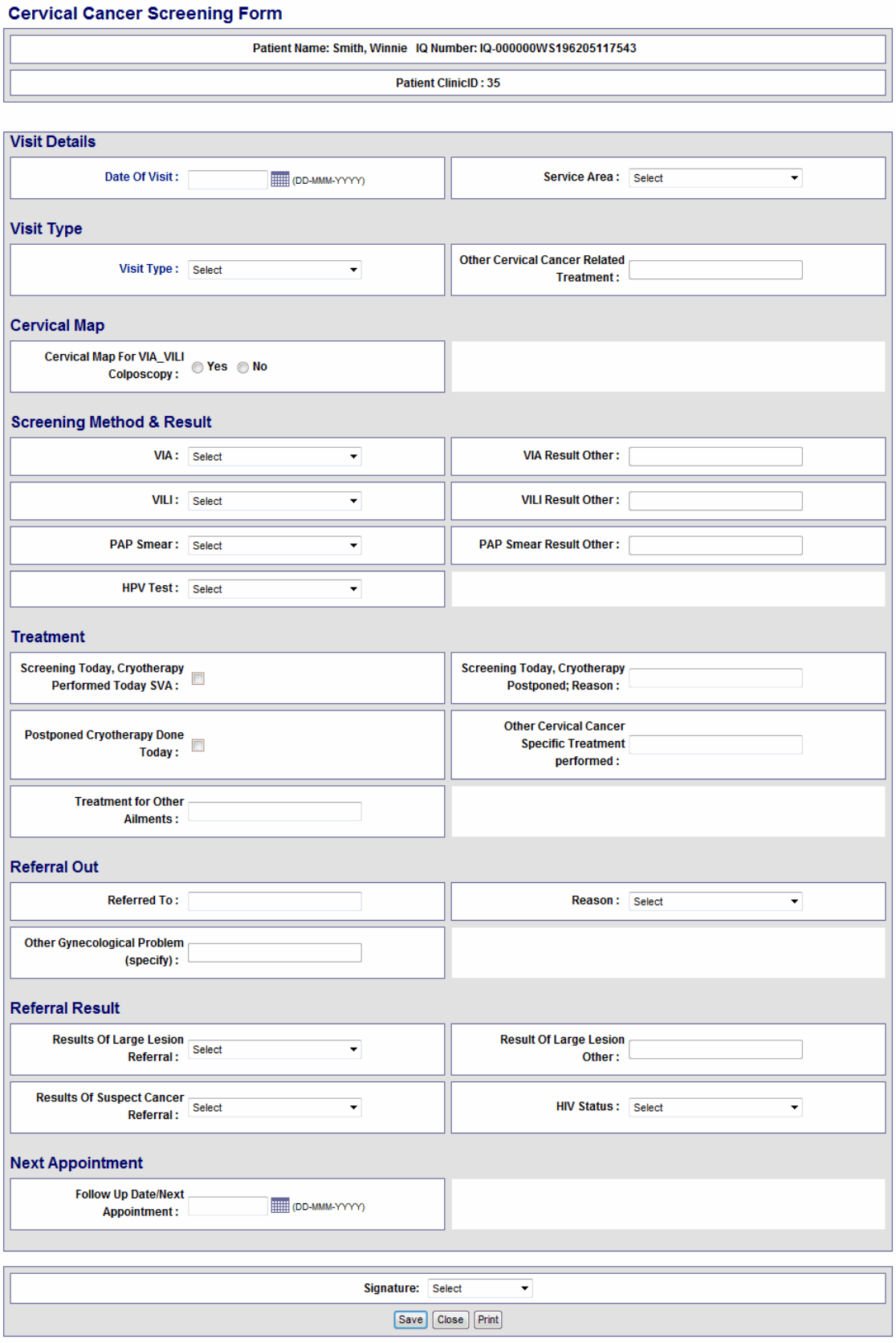

Cervical Cancer Screening Form

Patient Name: Smith, Winnie IQ Number: IQ-000000WS196205117543

Patient ClinicID : 35

Visit Details

Date Of Visit : (DD-MMM-YYYY)

Service Area : Select

Visit Type

Visit Type : Select

Other Cervical Cancer Related Treatment :

Cervical Map

Cervical Map For VIA_VILI Colposcopy : Yes No

Screening Method & Result

VIA : Select

VIA Result Other :

VILI : Select

VILI Result Other :

PAP Smear : Select

PAP Smear Result Other :

HPV Test : Select

Treatment

Screening Today, Cryotherapy Performed Today SVA :

Screening Today, Cryotherapy Postponed; Reason :

Postponed Cryotherapy Done Today :

Other Cervical Cancer Specific Treatment performed :

Treatment for Other Ailments :

Referral Out

Referred To :

Reason : Select

Other Gynecological Problem (specify) :

Referral Result

Results Of Large Lesion Referral : Select

Result Of Large Lesion Other :

Results Of Suspect Cancer Referral : Select

HIV Status : Select

Next Appointment

Follow Up Date/Next Appointment : (DD-MMM-YYYY)

Signature: Select

Save Close Print

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Data Dictionary

Cervical Cancer Screening Form							
Form/ Registration	**Field Name (no spaces)**	**Labeled (In the form)**	**Predefined field / existing**	**Options/ list/units**	**Nature of the field**	**Associated fields**	**Required Field (Yes/ No)**
	VisitDate	Date	Yes		Date		Yes
	ServiceAreaCx	Service Area	No	MCH/FP, CCC, GOPC, Outreach, OPD, Other	Select List		
Visit Type	CxVisitType	Visit Type	No	Screening, Postponed Cryotherapy Visit, Post Treatment Complication, Other Cervical Cancer related Treatment			Yes
Visit Type	CxScreening	Screening	No			CxVisitType_Screening	
Visit Type	CxPostTreatmentComp		No	Cryotherapy, LEEP, Other	Select List	CxVisitType_Treatment Complication	
Visit Type	CxPostTreatmentCompOther		No		Text single Line	CxVisitType_Other	
Cervical Map	CervicalMap	Cervical Map	No		Yes/No		
Screening Method & Result	VIAResult	VIA Result	No	VIA Positive, VIA Negative, Suspicious of cancer,	Select List		

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Cervical Cancer Screening Form							
				Other			
Screening Method & Result	VIAResultOther	VIA Result Other	No		Text single Line	VIAResult_Other	
Screening Method & Result	VILIResult	VILI Result	No		Select List		
Screening Method & Result	VILIResultOther	VILI Result Other	No		Text single Line	VILIResult_Other	
Screening Method & Result	PAPResult	PAP Smear Result	No		Select List		
Screening Method & Result	PAPResultOther	PAP Smear Result Other	No		Text single Line	PAPResult_Other	
Screening Method & Result	HPVResult	HPV Test Result	No		Select List		
Treatment	CxTreatmentSVA	Screening today, Cryotherapy Performed Today	No		Checkbox		
Treatment	CxTreatmentCryoPost	Screening today, Cryotherapy postponed; Reason	No		Text single Line		
Treatment	CxTreatmentPostCryoToday	Postponed Cryotherapy done	No		Checkbox		

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Cervical Cancer Screening Form							
		today					
Treatment	CxTreatmentOtherToday	Other cervical cancer specific treatment performed	No		Text single Line		
Treatment	CxTreatmentOtherAilments	Treatment for other ailments	No		Text single Line		
Referral Out	ReferredTo	Referred To	Yes		Text single Line		
Referral Out	CxReferredOutReason	Reason	No	Site does not have cryotherapy machine, Large lesion, Suspect cancer, Other Gynecological problem (specify):	Select List		
Referral Out	CxReferredOtherGynae	Other Gynecological problem (specify)	No		Text single Line	CxReferredOutReason	
Referral Result	CxLargeLesionResult	Results of Large Lesio	No	LEEP Performed, Other	Select List		

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Cervical Cancer Screening Form							
		n Referral					
Referral Result	CxLargeLesionResultOther	Result of Large Lesion Other	No		Text single Line	CxLargeLesionResult_Other	
Referral Result	CxSuspectCancerResult	Results of Suspect Cancer Referral	No	Cancer Confirmed, Cancer Not Confirmed	Select List		
HIV Status	HIVStatus	HIV Status	Yes	Positive, Negative, Unknown	Select List		
Next Appointment	AppointmentDate	Follow Up Date/ Next Appointment	Yes		Date		

10.4.10 TB Intensive Case Finding

Purpose

When and Who Completes the Form

Fill in a New TB Intensive Finding Form

The active technical area should be TB Intensive Finding

1. From the Patient Home Page, click on the Create New Form link and select either the TB Enrollment, TB Intensive Finding or TB Drug Collection and Adherence
2. Fill in the form, making sure you fill in the required fields. Note that some of the fields will be auto populated.
3. Click Save
4. IQCare displays a message alerting you of any required fields not filled in
5. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

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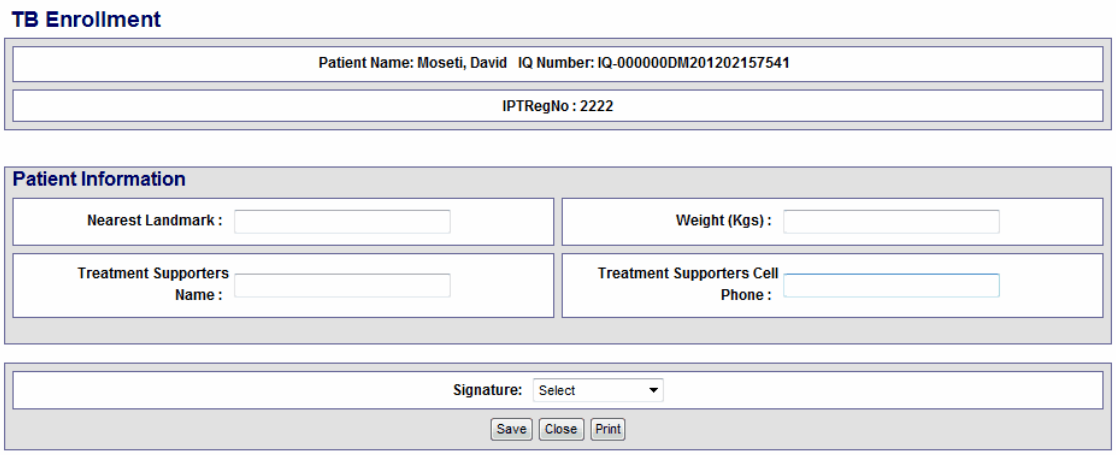
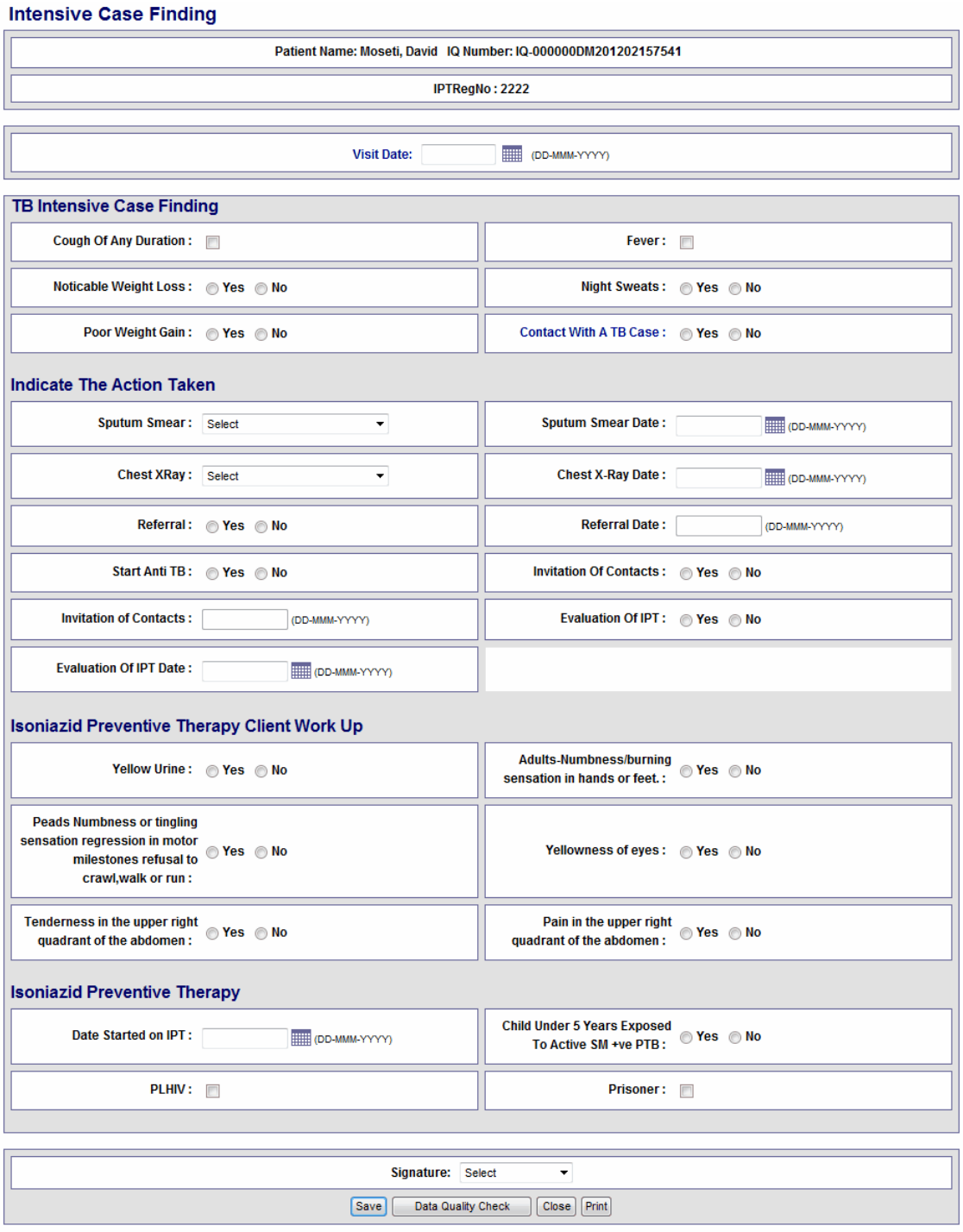
Update a TB Intensive Finding Form

1. To access a previously filled TB Intensive Finding form (TB Enrollment, TB Intensive Finding or TB Drug Collection and Adherence) click on View Existing Forms and find the form you want to update and click the link
2. Update the form
3. Click Save

TB Enrollment Form Example



TB Intensive Case Finding Form Example


Intensive Case Finding
Patient Name: Moseti, David IQ Number: IQ-000000DM201202157541
IPTRegNo : 2222
Visit Date: (DD-MMM-YYYY)
TB Intensive Case Finding
Cough Of Any Duration :
Fever :
Noticable Weight Loss : Yes No
Night Sweats : Yes No
Poor Weight Gain : Yes No
Contact With A TB Case : Yes No
Indicate The Action Taken
Sputum Smear : Select
Sputum Smear Date : (DD-MMM-YYYY)
Chest XRay : Select
Chest X-Ray Date : (DD-MMM-YYYY)
Referral : Yes No
Referral Date : (DD-MMM-YYYY)
Start Anti TB : Yes No
Invitation Of Contacts : Yes No
Invitation of Contacts : (DD-MMM-YYYY)
Evaluation Of IPT : Yes No
Evaluation Of IPT Date : (DD-MMM-YYYY)
Isoniazid Preventive Therapy Client Work Up
Yellow Urine : Yes No
Adults-Numbness/burning sensation in hands or feet. : Yes No
Peads Numbness or tingling sensation regression in motor milestones refusal to crawl,walk or run : Yes No
Yellowness of eyes : Yes No
Tenderness in the upper right quadrant of the abdomen : Yes No
Pain in the upper right quadrant of the abdomen : Yes No
Isoniazid Preventive Therapy
Date Started on IPT : (DD-MMM-YYYY)
Child Under 5 Years Exposed To Active SM +ve PTB : Yes No
PLHIV :
Prisoner :
Signature: Select
Save
Data Quality Check
Close
Print

TB Drug Collection and Adherence

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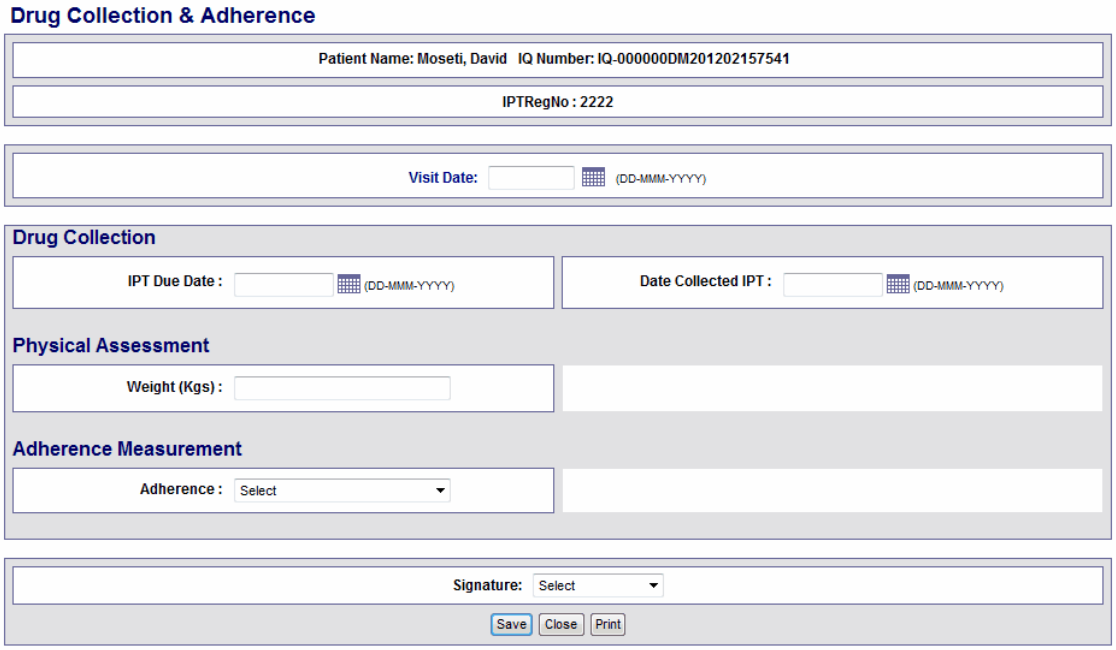

Data Dictionary

10.4.11 PEP Register

Introduction

This register covers information needs for the management of health workers who may be exposed to Human Immuno-Virus or Hepatitis B Virus during the course of their work, other workers, such as the police, people who may be sexually assaulted and exposed to HIV or any other person who may be exposed to HIV.

Purpose

This register is an extension of the existing register which was designed for health workers only. This edition covers all other persons who come to the facility to seek post-exposure interventions at the facility.

When Completed

Depending on how the facility is organized, the first seven (7) columns can be completed when the client contacts the facility and the remaining columns can be updated as the service is offered or the intervention is provided.

Who Completes the Form

Each facility can decide who completes the register, bearing in mind aspects such as the training of the staff member and confidentiality.

Fill in a New PEP Register Form

The active technical area should be PEP Register

1. From the Patient Home Page, click on the Create New Form link and select the PEP Register.
2. Fill in the form, making sure you fill in the required fields. Note that some of the fields will be auto populated.

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3. Click Save
4. IQCare displays a message alerting you of any required fields not filled in
5. IQCare displays a message alerting you of a successful save and asks you if you wish to exit or stay on the form (for continued field data entry.)

Update PEP Register Form

1. To access a previously filled PEP Register form click on View Existing Forms and find the PEP Register and click the link
2. Update the form
3. Click Save

PEP Example Form

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PEP Register

Patient Name: Moseti, David IQ Number: IQ-000000DM201202157541

PEP Number : 77777

Visit Date: (DD-MMM-YYYY)

Client Information

Client type : Select
Other Exposure Nature :
Cadre : Select
Other Health Worker :
Non Health Worker :

Description of Exposure

Date Of Exposure : (DD-MMM-YYYY)
Timing Of Exposure (Hrs) :
Location Of Exposure : Select
Other Exposure Location :
Nature Of Exposure : Select
Other Exposure Nature :
Severity Of Exposure : Select

Specimen Status

HIV Specimen Status : Select
HBV Specimen Status : Select
Risk Of HIV : Select

PEP History

PEP For Adults : Select
PEP For Adults (duration) :
PEP For Children : Select
PEP For Children (duration) :

Baseline Status

HIV Status : Select
HBV Status : Select

Current PEP

Start Date : (DD-MMM-YYYY)
Start Time :

PEP Completion

PEP Completed : Yes No
Date PEP completed : (DD-MMM-YYYY)
Reason for not completing PEP : Select
Other Reason Not Completed PEP :

HIV Status At

HIV Status At 3 Weeks : Select
HIV Status At 3 Months : Select
HIV Status At 6 Months : Select

Remarks

Remarks :

Signature: Select

Save Close Print

▼ **Data Dictionary**

PEP Register							
Form/ Registration	**FieldName (no spaces)**	**Labeled (In the form)**	**Options/ list/units**	**Nature of the field**	**Associated fields**	**Required Field (Yes/ No)**	**Data Quality Check (Yes/ No)**
Client Information	ClientType	Client Type		Select list			
Client Information	OtherExposureNature	Other Exposure Nature		Text single line			
Client Information	Cadre	Cadre		Select list			
Client Information	OtherHealthWorker	Other Health Worker		Text single line	Cadre		
Client Information	NonHealthworker	Non Health worker		Text single line			
Description of Exposure	Date	Date of exposure		Date		Yes	
Description of Exposure	ExposureTime	Timing of Exposure		Text single line		Yes	
Description of Exposure	ExposureLocation	Location of Exposure	Medical Ward, Surgical Ward, Theatre, Dental Clinic, OP/ MCH, Laundry, VCT, Other Location	Select list	OtherExposureLocation		
Description of Exposure	OtherExposureLocation	Other Exposure Location		Text single line			
Description of Exposure	ExposureNature	Nature of exposure	Occupational, Sexual Assault, Other	Select list			
Description of Exposure	OtherExposureNature	Other exposure		Text single line	ExposureNature		
Description of Exposure	ExposureSeverity	Severity of exposure	Superficial, Deep	Select list			
Specimen status	HIVSpecimenStatus	HIV specimen status	HIV Positive, HIV Negative, HIV Status	Select list			

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PEP Register							
			Unknown				
Specimen status	HBVSpecimenStatus	HBV Specimen Status	HBVsAG Negative, HBVsAG Positive, Vaccinated, Unknown	Select list			
Specimen status	HIVRisk	Risk of HIV	High, Medium	Select list			
PEP History	PEPAdultDuration	PEP for Adults (duration)		Numeric			
PEP History	PEPAdultRegimen	PEP for Adults		Select list			
PEP History	PEPChildDuration	PEP for children (duration)		Numeric			
PEP History	PEPChildRegimen	PEP for children		Select list			
Baseline Status	HIVBaselineStatus	HIV	HIV Positive, HIV Negative, HIV Status Unknown	Select list			
Baseline Status	HBVBaselineStatus	HBV	HBVsAG Negative, HBVsAG Positive, Vaccinated, Unknown	Select list			
CurrentPEP	CurrentPEPStart	StartDate		Date			
CurrentPEP	CurrentPEPTime	StartTime		Text single line			
PEP Completion	PEPCompleted	PEP Completed		Yes, No			
PEP Completion	CurrentPEPComplete	Date PEP completed		Date			
PEP Completion	ReasonNotCompletingPEP	Reasons for not completing PEP		Select list			
PEP Completion	OtherReasonNotCompletePEP	Other Reason Not Conmpleted PEP		Text single line			
HIV Status at	3weeksHIVStatus	HIV status at 3 weeks	Positiev, Negative, Unknown	Select list			
HIV Status at	3monthsHIVStatus	HIV status at 3 months	Positiev, Negative, Unknown	Select list			

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PEP Register							
HIV Status at	6months HIV Status	HIV status at 6 months	Positiev, Negative, Unknown	Select list			
Remarks	Remarks	Remarks		Text multi Line			

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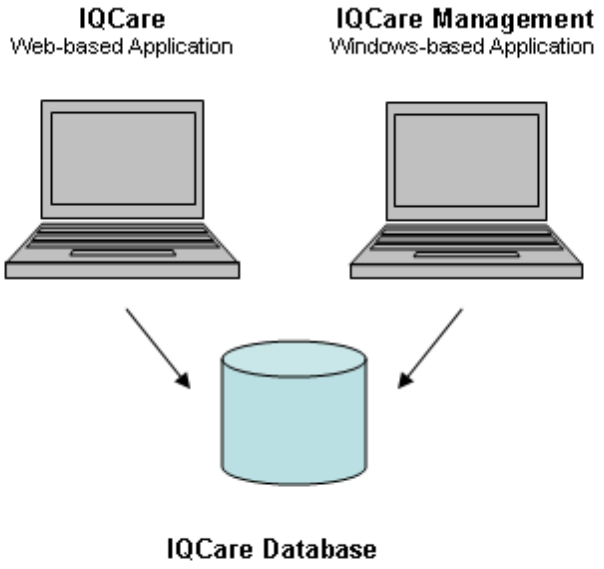
Part

11 IQCare Management/Form Builder

IQCare Management is a Windows-based administrative module that goes hand-in-hand with IQCare, the web-based patient management and monitoring system. The two key areas of administration is the database management features and the form builder.

It's in the IQCare Management that you can merge IQCare databases and optimize database indexes for enhanced performance. The form builder allows you to define fields and create forms that are used in the IQCare application where users enter data and run reports.



IQCare and IQCare Management both access the same database.

11.1 Login

- Log in with the same Login Name and Password used for IQCare
- Facility/Satellite is determined by the Facility/Satellite set up in IQCare
- Access control is configured in IQCare – User Group Configuration

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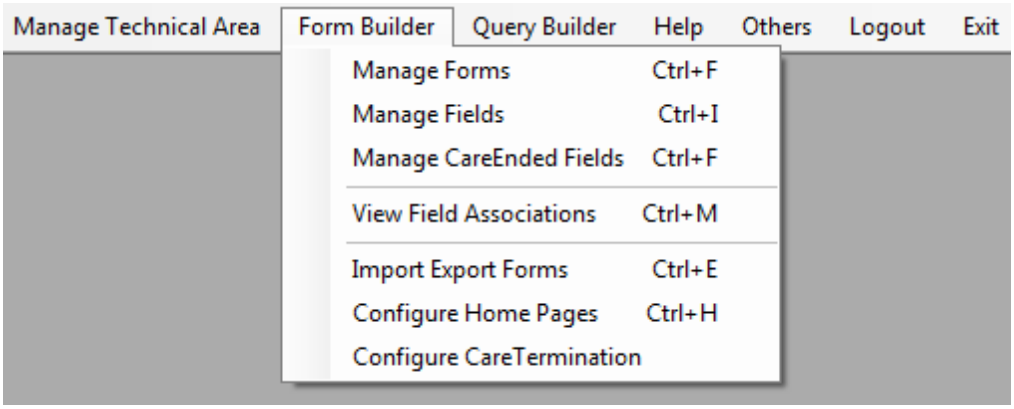
11.2 Navigation



Navigation Links	Description
Service Administration	This opens a window that allows you to stop and start the IQCare Service. The IQCare Service a machine connection protocol that allows different machines to communicate. The IQCare Service must be running in order for IQCare to communicate with the IQCare database.
DB Operations	
• Upsize	When a database is being migrated from an Access type database to an SQL type data, the Access database must first be “upsized”. This process changes the Access database into an SQL type database.
• DB Migration	This feature identifies the upsized database which will be

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	migrated to a blank IQCare database and runs the database migrations scripts.
• DB Merge	This feature merges two IQCare databases of the same version into one database.
• Refresh System Cache	When new select or multi-select lists are created and entries are added to the lists, the system cache must be refreshed so that these new lists and entries are visible in IQCare forms. This is the same function as found under the Administration/ Refresh System Cache found in IQCare.
• Rebuild Custom Reports DB	When new fields are identified via the form builder, or data has been added into forms then before running customer reports, the customer report tables need to be refreshed. This is the same function as found when you open Custom Reports and IQCare asks you if you want to refresh the Custom tables.
• IQCare DB Maintenance	Over time the database performance can erode as data is added into the data and new forms are added to the application. Indexes are added to columns for data that is frequently queried to increase the speed at which the computer pulls data from the database. These indexes need to be rebuilt from time to time to maintain the best performance. It's recommended to use the IQCare DB Maintenance feature on a monthly basis.
Form Builder	
• Manage Forms	All of the existing forms created through IQCare Form Builder are visible through the Manage Forms feature. From the Manage Forms screen you can create a new form, publish an existing form to IQCare or unpublish a form visible in IQCare.
• Manage Fields	All of the pre-defined fields and custom fields are managed in this section.
• View Field Associations	This non-editable view shows all of the fields and which forms the fields are used in.
• Import Export Forms	This feature allows you to share your forms with others. The export feature allows you to export the forms you have build to .XML files that you can mail to other colleagues. The import feature allows you to install or import forms that your colleagues what to share with you. Once imported, the form a form will be visible in the Manage Forms screen in the "In Progress" state.
Help	Displays the version of the IQCare Management module in use and the disclosure statement.
Others	
• Calculator	Opens a calculator
• Notepad	Open a notepad
Exit	Closes the IQCare Management screen and exits the application.

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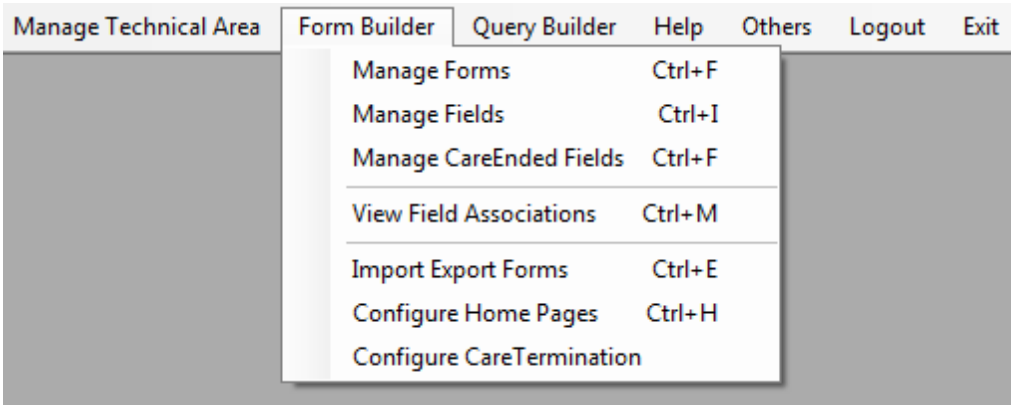
11.3 Access Rights

To be able to access all of the features in the IQCare Management module, including the Form Builder features, you must have access rights assigned in the User Group Administration. All of the features are available to be activated/in-activated in the "Forms" section of the User Group Administration.

The form builder features can be found in the top navigation of the IQCare Management window. When Form Builder access is turned off the navigation link in the IQCare Management module is removed so that that user can not access this Form Builder features. All of the other IQCare Management features are available.



The features that you must have assigned access are:

Feature/Form
Configure Care Termination
Configure Home Pages
Form Builder
Manage Fields
Manage Forms
Upsize

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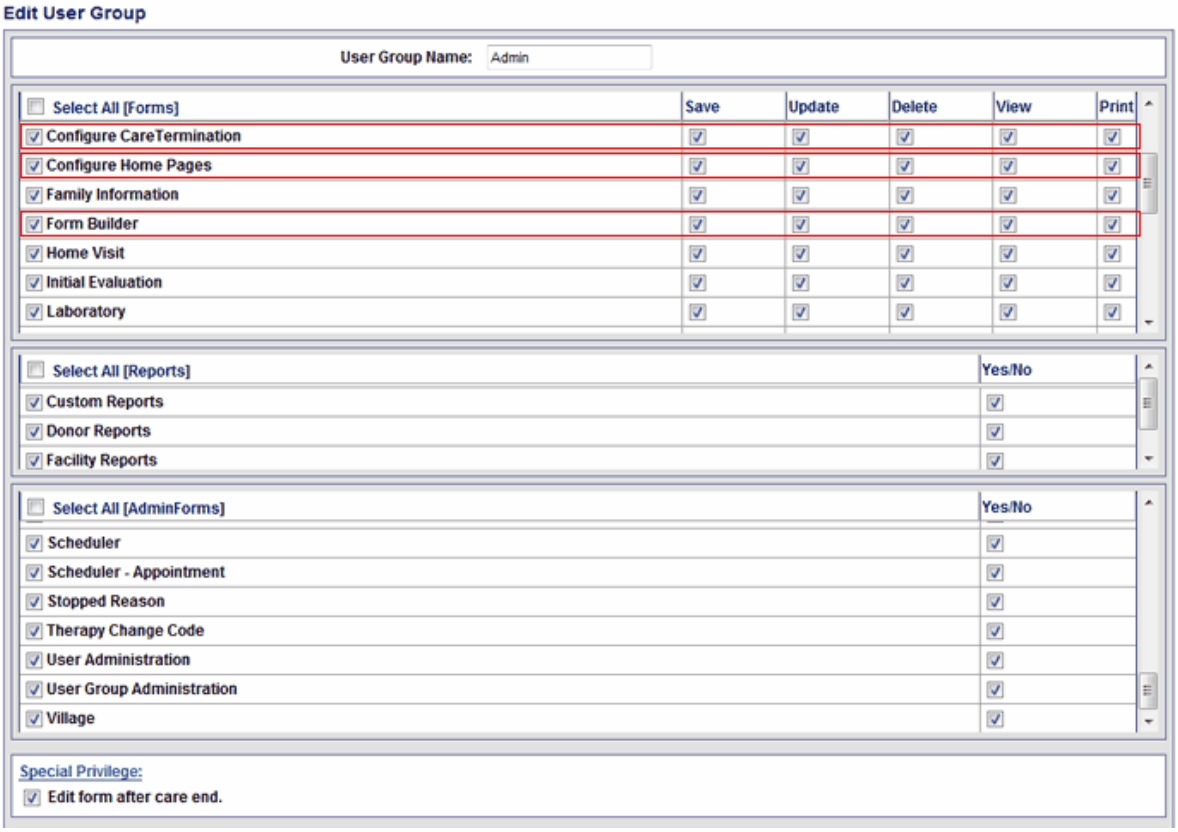

11.4 Preparation Steps

It's recommended that when you create new forms, you do some planning before you begin. By determining the fields you need up front and using the pre-defined fields in the system, you will save a lot of time and a lot of back and forth between managing fields and building the form.

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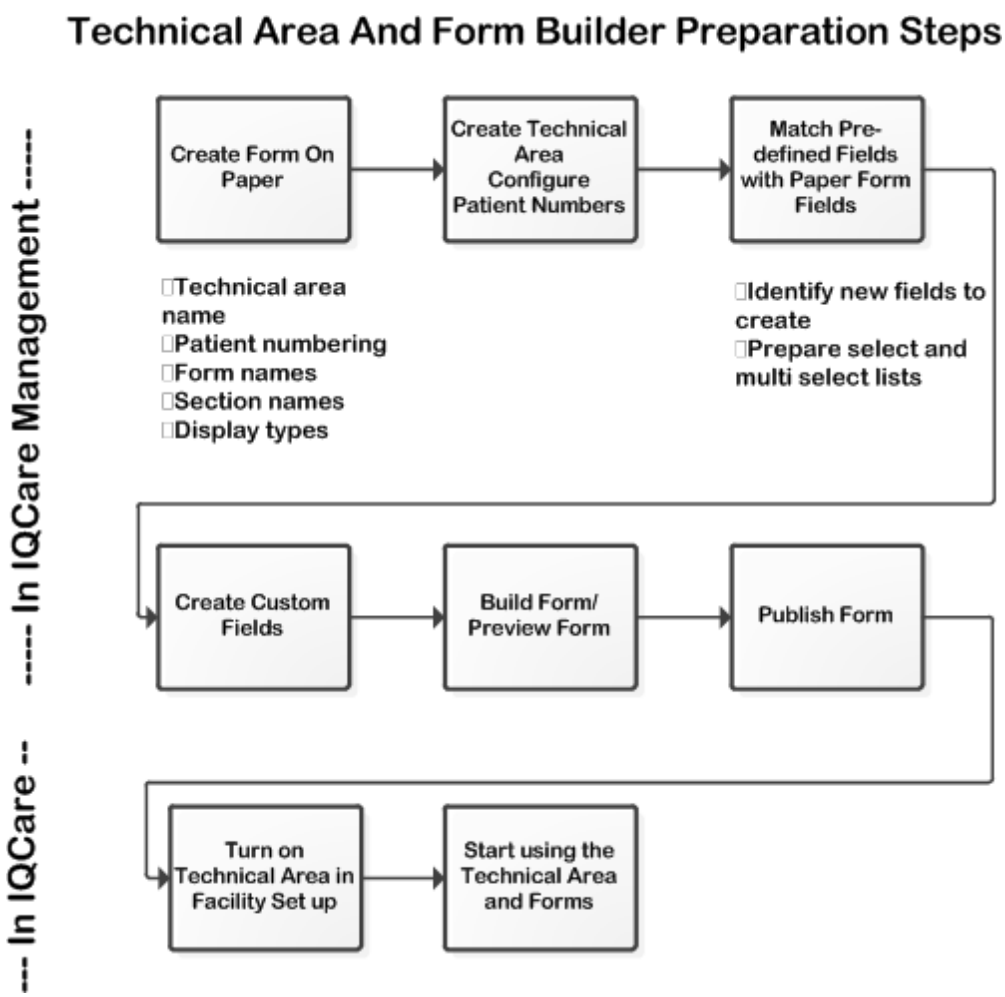
Technical Area And Form Builder Preparation Steps
---- In IQCare Management -----
--- In IQCare --
Create Form On Paper
Create Technical Area Configure Patient Numbers
Match Pre-defined Fields with Paper Form Fields
Technical area name
Patient numbering
Form names
Section names
Display types
Identify new fields to create
Prepare select and multi select lists
Create Custom Fields
Build Form/ Preview Form
Publish Form
Turn on Technical Area in Facility Set up
Start using the Technical Area and Forms

I. Preparation Steps

1. Create your form on paper so that you know the order of the fields

Define:

- Technical area name (SMART ART and PMTCT already defined)
- Form names
- Section names
- Display types
- Patient numbering

II. Technical Area Preparation

2. Create the technical area and patient identifiers

III. Field Preparation

3. Look at the Pre-defined fields (Manage Fields) list and match the pre-defined fields with fields on your form
4. Identify any new fields you need to create (Custom Fields)
5. Create these custom fields
6. For select list and multi-select lists, move to IQCare, Customize Lists and verify that the existing lists have the correct entries. Make appropriate updates.

IV. Form Building Steps

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7. Go to Manage Forms
8. Create a new form
9. Select the technical area for the form
10. Select if the form is single or multi entry
11. Section by section, build the form.
12. If you find that you are missing a field or you change your mind about field, no problem. Save your work and return to the Manage Fields section and make updates.
13. Return to Form Builder, find your In Progress form and continue to build the form
14. Use the Preview button to see the layout of the form
15. When you are satisfied, Publish the form to IQCare.

11.5 Manage Technical Areas

A technical area is any grouping of forms/data you want to collect. It can be a full program or possibility part of a program. For example a technical area could be all of the indicators for a TB program or it could be the collection of testing and counseling data for all women who enroll at an ante natal clinic which may be outside of a PMTCT program.

All forms, data and transactions will be designated to a technical area. By assigning each variable to a technical area IQCare can correctly report the technical area or program a service was provided. This is especially important when programs such as HIV Care and PMTCT overlap. Pharmaceuticals that are dispensed and laboratory tests performed can be traced back to the originating technical area.

Pre-Defined Technical Areas
Currently in IQCare there are two pre-defined technical areas: HIV Care StaticForms and PMTCT. With these pre-defined technical areas also have pre-defined fields sets available in form builder.

Patient Identifiers
Each technical area can have as many as 4 patient identifiers associated with it. You can define new patient identifiers or use existing identifiers already defined for other technical areas.

Technical Areas that cannot be edited
- The HIV Care Static Forms and PMTCT technical areas cannot be edited.
- The HIV Care Static Forms have the PatientEnrollmentID and the PatientClinicID patient identifiers pre-defined. These cannot be changed.
- The PMTCT technical area has the ANC Number, PMTCT Number, Admissions Number and Post Natal number is already defined. These cannot be changed.

The Manage Technical Areas Grid
- To see all of the technical areas, click on the Manage Technical Areas link in the menu navigation.
- This grid show all the technical areas created for the database, the patient identifiers and if the technical area has been published. If the technical area has been published, it becomes available for use in the other areas of the form builder as well as in the Facility Set up page in IQCare.
- To publish or unpublish a technical area, click on the text in the row of the technical area you want to change.

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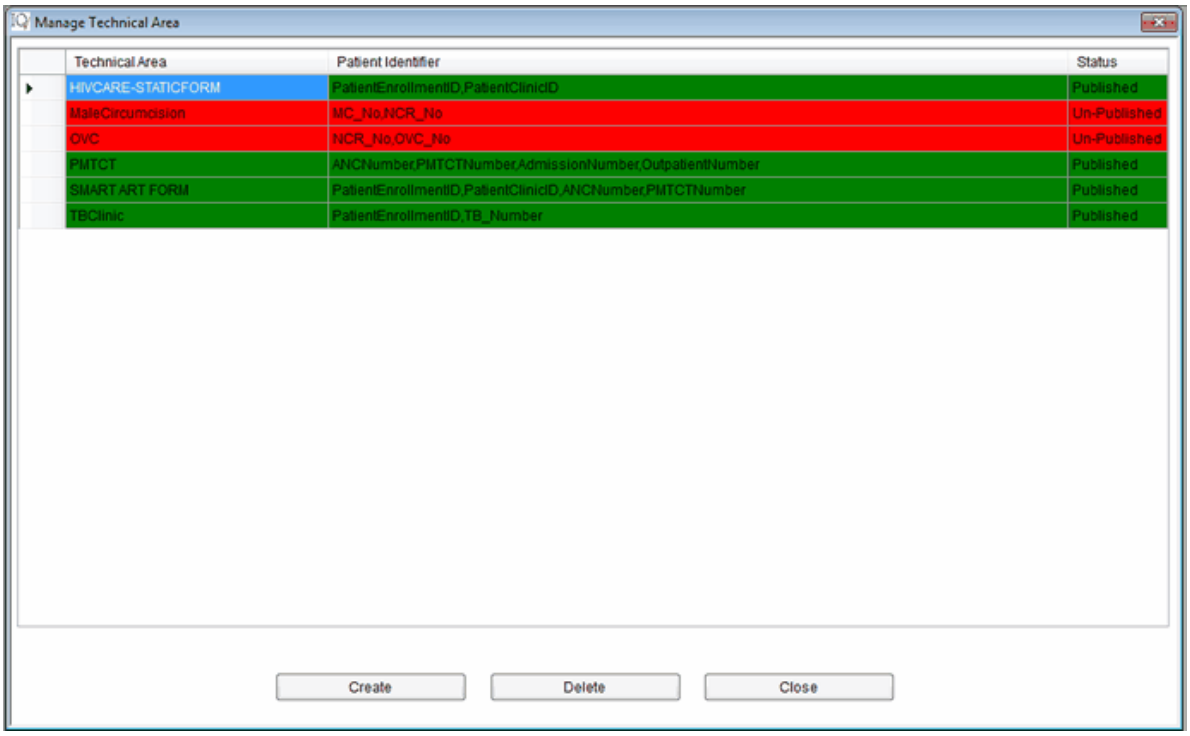

11.5.1 Create Technical Area

To create a new technical area:

1. Click on Create Technical Area in the Manage Technical Area grid
2. Enter the technical area name. The name may have spaces such as "Community Outreach"
3. If there is a new patient identifiers associated with the technical area, enter the patient identifier name and select the type. If the identifier type has letters or slashes, then you need to select the Text SingleLine; if it is only numbers, select Numeric.
4. Click submit to save the name in the identifier.

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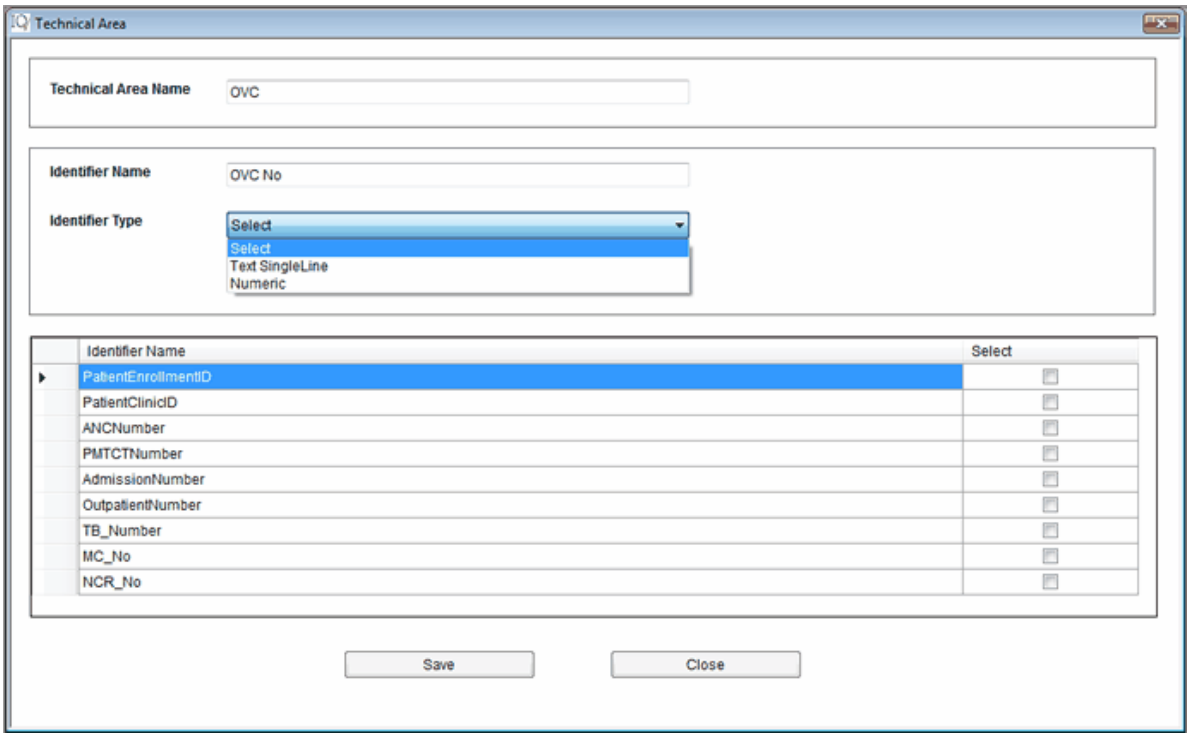
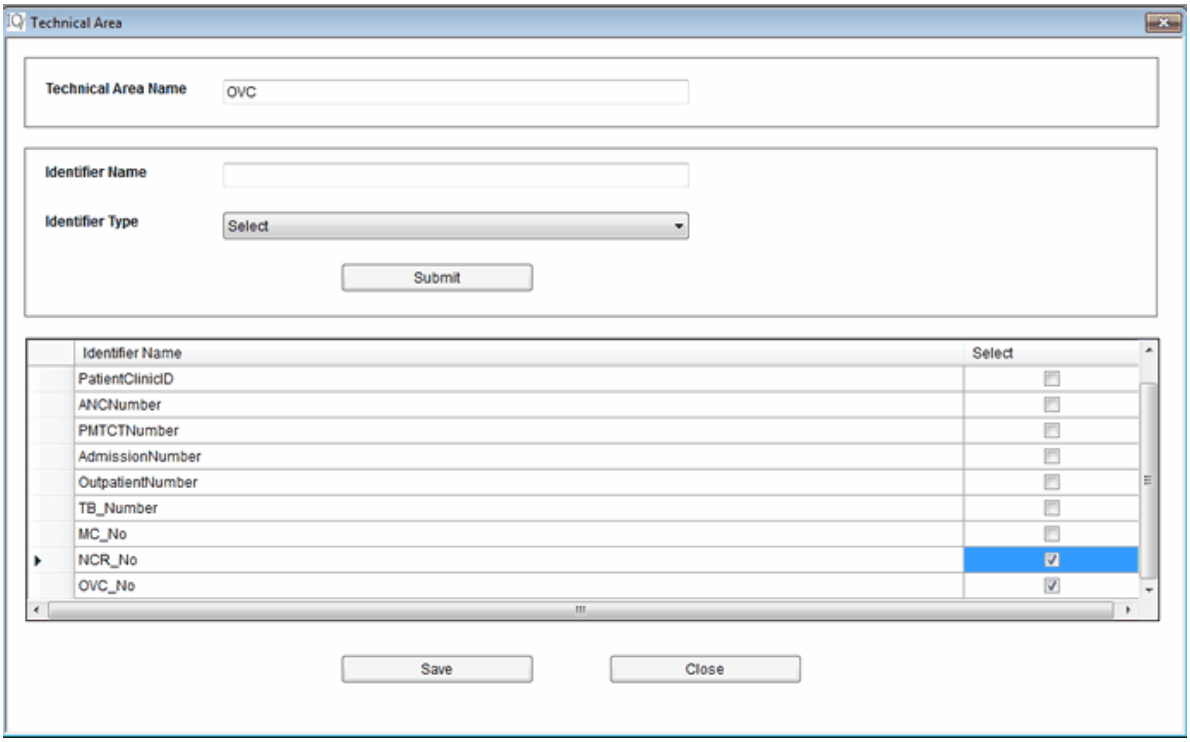


5. Once submitted, the name of the newly created identifier is displayed at the end of the list below and the identifier is already selected.
6. If there are existing identifiers shared with other technical areas, select those as well.You can select up to four patient identifiers per technical area.



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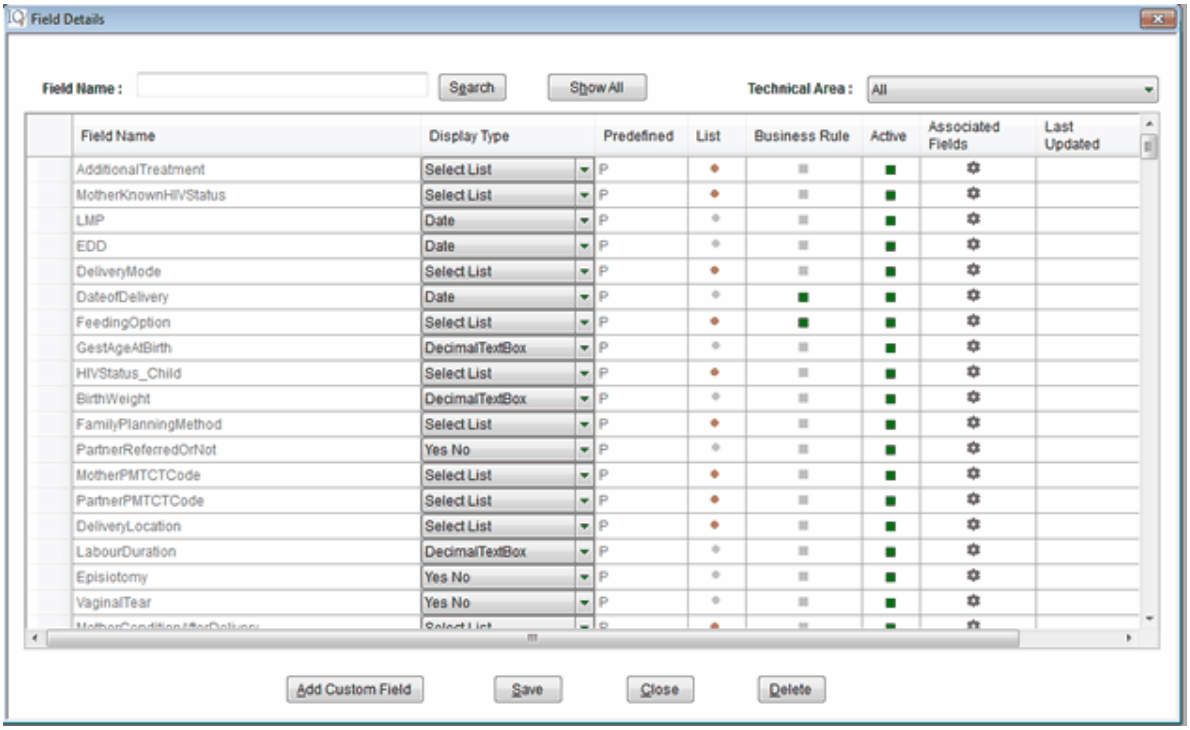
7. Click Save to save the technical area and the patient identifiers.

11.6 Manage Fields

This is the first place to start before you create new forms or update existing forms. A survey of all of the PMTCT register fields was done, and the pre-defined field set represents the union of all of the different fields across Kenya, Tanzania, Uganda and Nigeria registers. Some fields may need to be labels differently in your country, but the field intent is the same.



Column Name	Function/Use
Field Name	Lists the pre-defined and custom fields available for use in forms click on the column title and the fields will re-arrange in ascending or descending order
Display Type	The display type that will display in a form; it is related directly to the field type.
Predefined	P=Predefined; C=Custom Click on the column title and the Predefined and Custom fields will organize in groups.
List	Orange dot means the field is either a select list or a multi-select list; If this is a custom field, click on the dot to see the default list
Business Rule	The green square means that a business rule has been applied to the field Click on the square an the business rule will display
Active	The green square means that the field is active and always visible for selection

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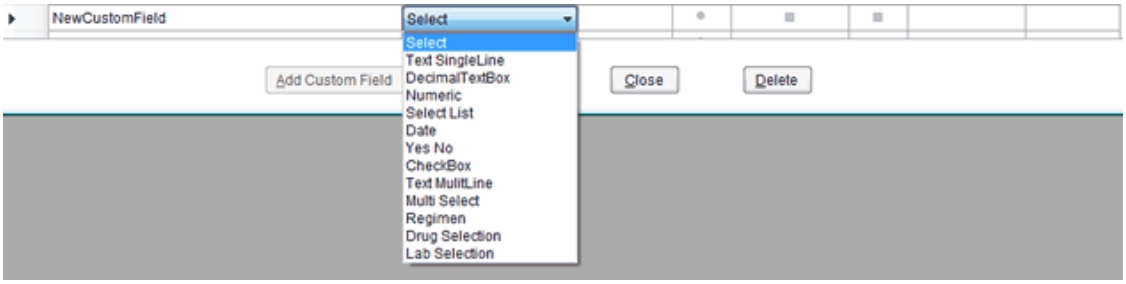
	when building forms Pre-defined fields are always active and can not be inactivated Custom fields can be inactivated
Associated Fields	The gray/black flower icon shows that the select list, multi-select list or yes/no field has been configured for the conditional display of fields
Last Updated	Displays the data a Custom field was last updated
Updated By	Displays the user who last updated the field

11.6.1 Display Types and Business Rules

When you are creating custom fields, you have the option of selecting from a number of different field types. The field types will determine the kind of data input can/will be allowed in IQCare forms.

Field types available

These display types are available for use when building forms. Each display type can be configured with business rules which control if a field is enabled or disabled depending on patient criteria, if a field is auto populated or the field should be data quality checked or required for saving. See Business Rule Definitions for more details.



Display Type	Used For	Business Rule Options
TextSingleLine	Single line text	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Data Quality Check Required Field
DecimalTextBox	Decimal number OR Single line text box	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Data Quality Check Min Value Max Value Number Decimal Required Field
Numeric	Integer number	Active if current age >= min __ and < max __

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		years Active if female Active if male Auto populate Data Quality Check Min Value Max Value Required Field
Select List	Select list	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Data Quality Check Required Field Conditional Fields
Date	Date	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Date must be strictly greater than today's date Date must be strictly less then today's date Date must be strictly greater than date of birth Data Quality Check Required Field
Yes No	Yes No	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Data Quality Check Required Field Conditional Fields
Text MultiLine	Multi-line text box	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Required Field Data Quality Check
Checkbox	Check box	Required Field Data Quality Check
Multi Select List	Multi-select list	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Required Field

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		Data Quality Check Conditional Fields
Regimen	Any kind of drug regimen with the display of A/B/C	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Data Quality Check Regimen (Drug type filter) Required Field
Drug Selection	Drug selection within a form	Filtered Drug Button Required Field
Lab Selection	Lab selection within a form	Active if current age >= min __ and < max __ years Active if female Active if male Lab selection Required Field

Regimen field type

The Regimen field type allows you save fields in the format of A/B/C. The original motivation for this field was for ARV Regimens which display with their abbreviations such as AZT/D4T/NVP. The use of this field has been generalized so that you can save any combination of drugs within a drug category.

In the IQCare user interface, a small button displays. When the user clicks on the button, the drug picker dialog displays, with the drugs filtered as per the configuration for this field. The user can select any number of drugs; the regimen is not constrained to three drugs. The regimen data is saved to the regimen table in the IQCare database.

Examples:
Filter = ARV Medications
Display = ARV medication abbreviations

Filter = Antituberculosis
Display = TB medications, full names

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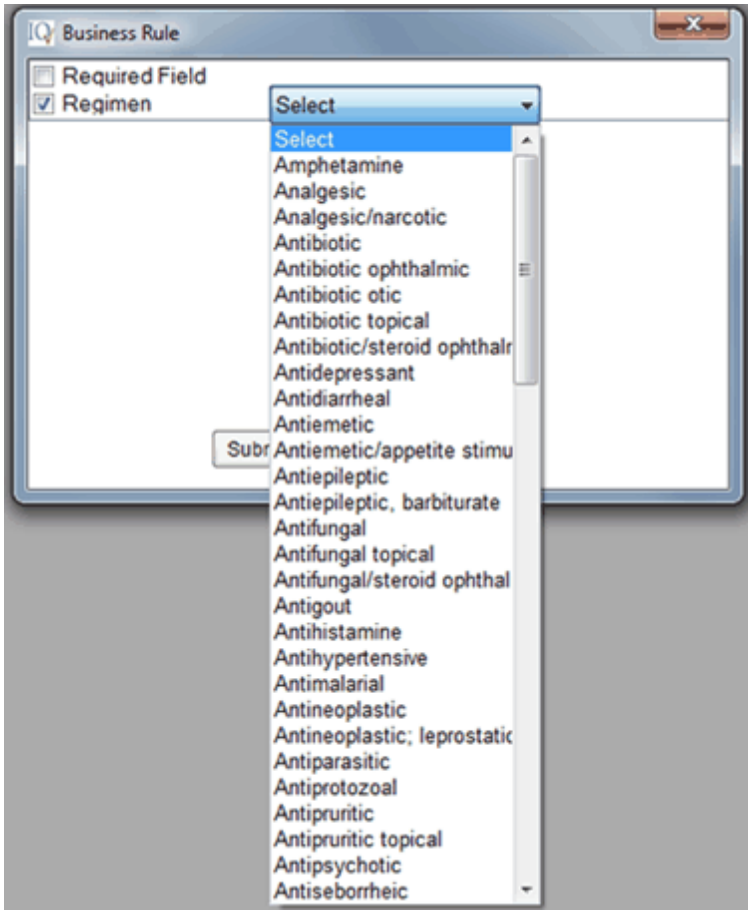

- Drug selection field type

  The Drug Selection field type allows you to save pharmacy details from within a form builder form. You configure the field by selecting the drug filter.

  In the IQCare user interface, a “Drug Selection” button displays. When the user clicks on the button, the drug picker dialog displays, with the drugs filtered as per the configuration for this field. The user can select any number of drugs. For each drug selected in the drug picker, IQCare displays a row of pharmacy fields – dose, frequency, duration, quantity prescribed and quantity dispensed. The duration field is a required field.

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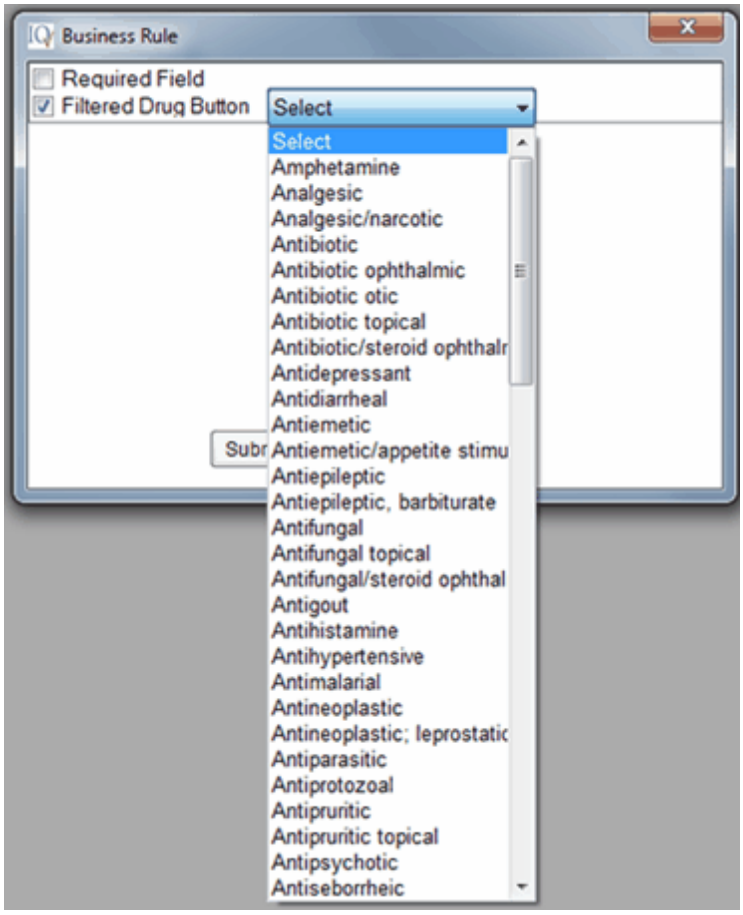
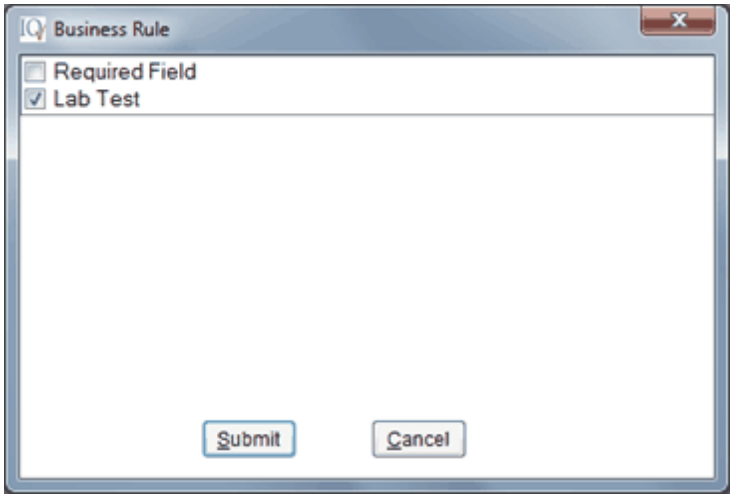


Lab selection field type

The Lab Selection field type allows you to save lab results from within a form builder form. In the IQCare user interface, a “Lab Selection” button displays. When the user clicks on the button, a list of all available lab tests displays; the user selects the labs and the lab name and result field(s) display in the IQCare form.



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11.6.2 Business Rule Definitions

Each field display type can be associated with one or more business rule. These rules are additive, meaning that all of the selected rules will fire either before the form is rendered or at the time the form is saved. See Display Types and Business Rules to see which rules are associated with a field display type.

Business Rule	Display Type Available	Definition

Active if current age >= min __ and < max __ years	TextSingleLine
	DecimalTextBox
	Numeric
	Select List
	Date
	Yes No
	Text MultiLine
	Lab Selection
		• If the patient's age is greater than or equal to a numeric value (integer age) AND strictly less then a numeric value (integer or decimal maximum age) then enable the field.
		• You must enter both range fields.
		  • For patients >= 18 years (adults), use a min age of 18 and a max age of 110 years (a number arbitrarily large)
		  • For patient <18 (children), use a min age of 0 and a max age of 18 years.
		• If this business rule is not checked, then the field is enabled for a patient of any age.
		• The business rule is fired upon rendering the form.

Active if female	TextSingleLine DecimalTextBox Numeric Select List Date Yes No Text MultiLine Lab Selection	• If the patient is female, then enable the field. • If the female and male business rule are both selected, then the field will be enabled for both female and males. This is the same result as not selecting the business rule. • The business rule is fired upon rendering the form.
Active if male	TextSingleLine DecimalTextBox Numeric Select List Date Yes No Text MultiLine Lab Selection	• If the patient is male, then enable the field. • If the female and male business rule are both selected, then the field will be enabled for both female and males. This is the same result as not selecting the business rule. • The business rule is fired upon rendering the form.
Auto populate	TextSingleLine DecimalTextBox Numeric Select List Date Yes No Text MultiLine	• The field will be auto populated with data from last saved entry. Another field will be displayed directly below for which data can be entered. • This field is not editable; it is for display and informational purposes only. • The business rule is fired upon

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Business Rule	Display Type Available	Definition
		rendering the form.
Data Quality Check	TextSingleLine DecimalTextBox Numeric Select List Date Yes No Text MultiLine Checkbox Regimen	• The rule validates that the field has been filled in; • If the field has not been filled in, then a user warning is displayed. • The form can be saved if the field is not filled in. • This business rule is fired upon saving the form.
Required Field	TextSingleLine DecimalTextBox Numeric Select List Date Yes No Checkbox Regimen Drug Selection Lab Selection	• The rule validates that the field has been filled in; • If the field has not been filled in, then a user warning is displayed. • The form cannot be saved if the field is not filled in. • This business rule is fired upon saving the form.
Min Value	DecimalTextBox Numeric	• The rule sets the minimum allowable value entered into the field. • This business rule is fired upon saving the form.
Max Value	DecimalTextBox Numeric	• The rule sets the maximum allowable value entered into the field. • This business rule is fired upon saving the form
Number Decimal	DecimalTextBox	• The rule allows decimal numbers to be entered into the field. • The field is set a decimal field upon rendering the form.
Date must be strictly greater than today’s date	Date	• The rule checks that the date entered is strictly greater than today's date • This business rule is fired upon saving the form.
Date must be strictly less than today’s date	Date	• The rule checks that the date entered is strictly less than today's date • This business rule is fired upon saving the form.
Date must be strictly greater than date of birth	Date	• The rule checks that the date entered is strictly greater than the patient's birth date • This business rule is fired upon saving the form.

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Business Rule	Display Type Available	Definition
Regimen	Regimen	• The rule sets the drug type filter for the regimen drug picker. When the regimen type field renders in an IQCare form, the user clicks on a button to display a list of drugs from which he/she selects to make up a regimen. • The rule is fired upon opening the drug picker.
Drug Filter Type	Drug Selection	• The rule sets the drug type filter for the drug button. When the drug selection type field is rendered in an IQCare form, the user clicks on the button to display a list of drugs from which he/she selects. • The rule is fired upon opening the drug picker.
Lab Selection	Lab Selection	• The rule sets the field type as a lab type. • The rule is fired upon rendering the form.

11.6.3 Placeholder Field

The Placeholder field is for formatting purposes only. IQCare care forms render using a "left-right" fields pairs. If you have an odd number of fields you may want to start a new row with a set of fields that are best put together as a pair. If this is the case, then you would use a placeholder formatting field to add a blank space and start a new row.

In this example below, no Placeholder field has been added to the form.

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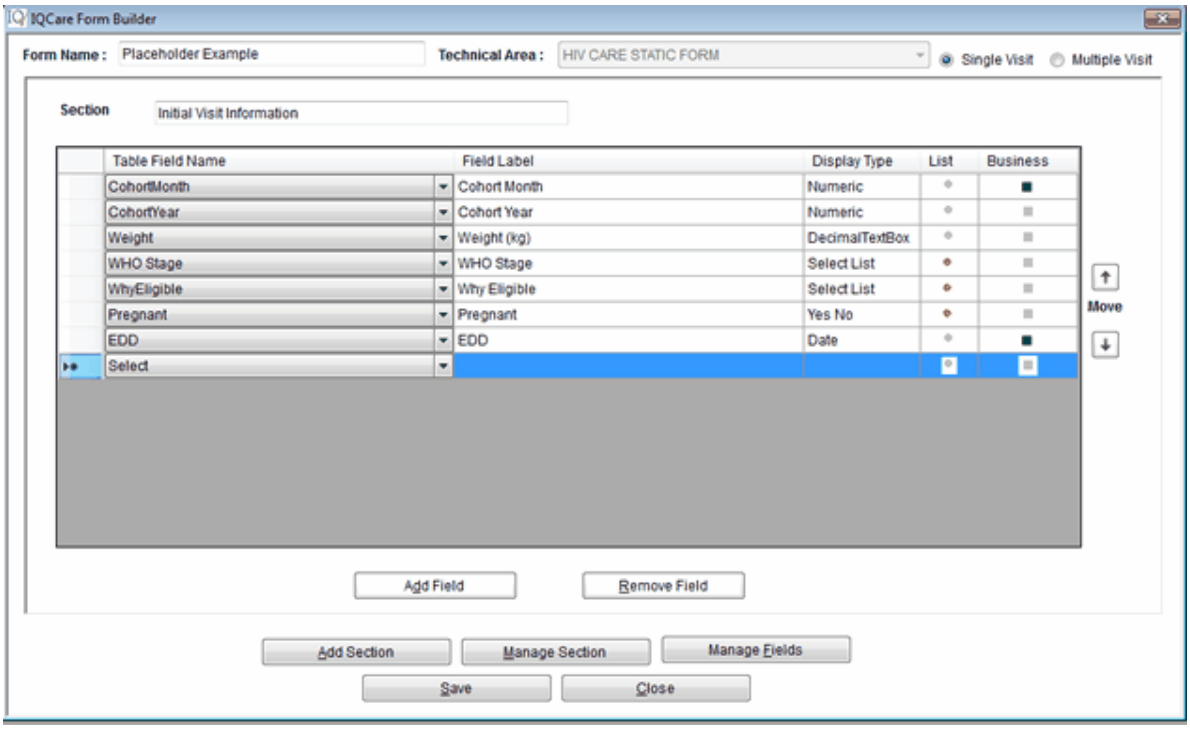
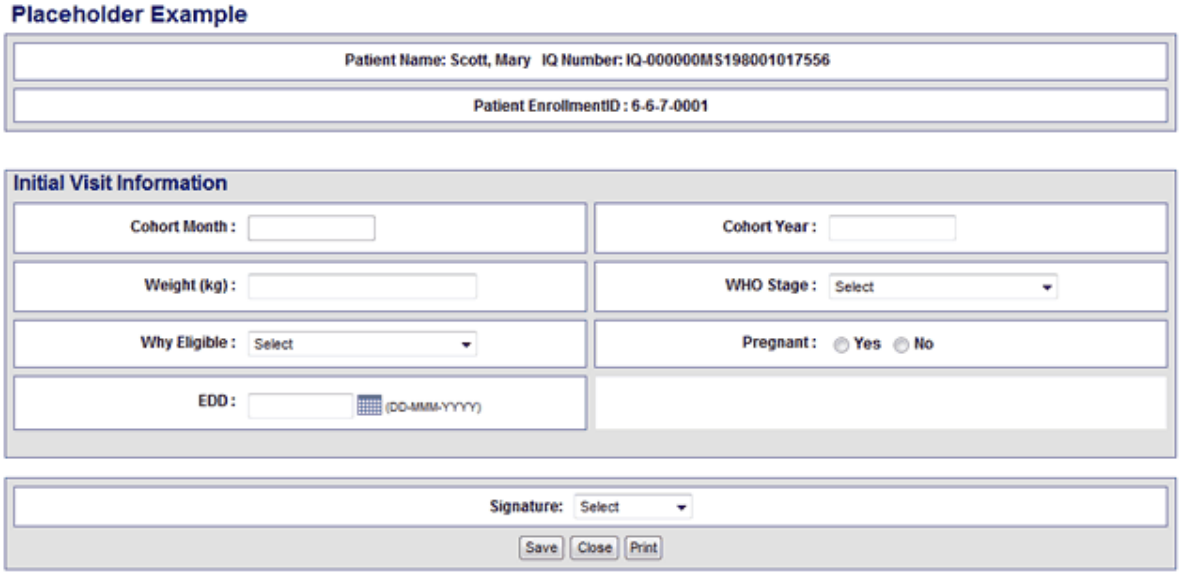


This is what the form looks like in IQCare. It might be easier for the data entry clerk or the clinician to fill this form in if there was a placeholder between the Weight field and the WHO Stage field (for example).



In this example, a Placeholder field has been added and place between the Weight and WHO Stage fields.

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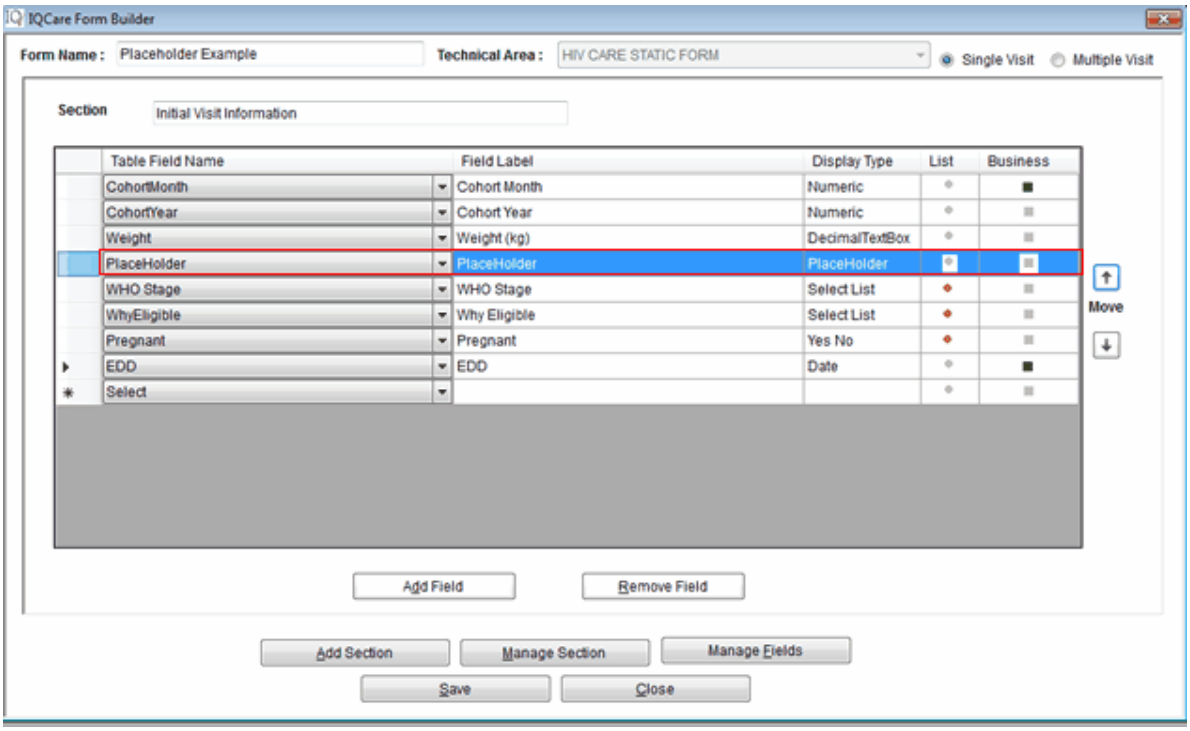
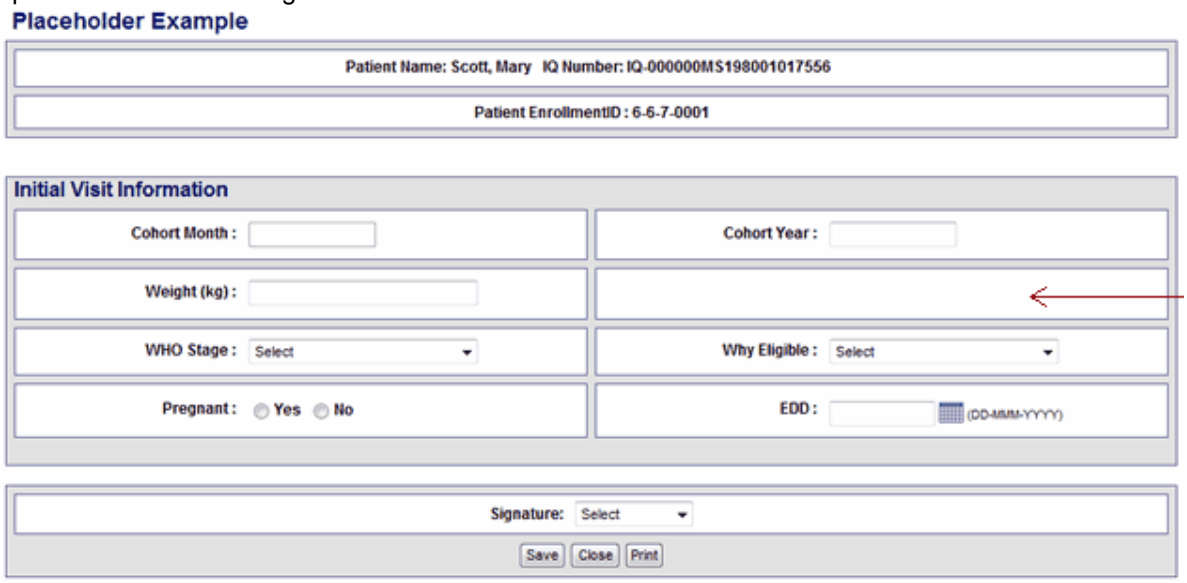


Here is how the form renders in IQCare. Not that where the Placeholder field is added, there is a blank space and the WHO Stage field starts on the left in a new row.



11.6.4 Pre-defined Fields

Facts about pre-defined fields

- Cannot be in-activated
- Cannot have the display type changed
- Cannot have their field name changed (but when using the field in a form, you can use any field label in your form that you want)
- Can only be used once in a form

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- Can be used in more than one form
- Pre-defined fields for one technical area are not available in another technical area
- Select list and multi-select list default entries must be updated via IQCare Customize List (Administration section)
- Saved data for some predefined fields are saved in existing IQCare tables. For the Smart ART Forms, fields that already existed in IQCare for the HIV Static Form set were used to the greatest extent possible. In particular, pharmacy and lab data are saved in the pharmacy and lab tables.
- Business Rules can be changed in the Manage Field view
- For the PMTCT technical area some of the pre-defined fields are used in pre-defined reports. These fields are indicated in the table below with at start "*" in the first column of the table.

11.6.4.1 PMTCT Fields

This is the list of pre-defined fields for the PMTCT technical area.

	Pre-defined Field Name	Display Type	Uganda	Nigeria	Tanzania	Kenya
	AdditionalTreatment	Select List	X			X
	AgreesToPartnerNotification	Yes No		X		
	APGARScore1	Select List	X			X
	APGARScore5	Select List				X
	BirthNotificationNo	Numeric				X
	BirthWeight	DecimalTextBox	X	X	X	X
	BloodLoss	Numeric				X
	BreastStatus	Select List	X			
	CervixStatus	Select List	X			
	ChildHIVStatus	Select List				
	CounseledForInfantFeeding	Yes No		X	X	X
	CounseledOn	Multi Select				X
	CounselledTestedHIVANC	Yes No				X
	CounselledTestedHIVMAT	Yes No				X
	DateOfDischarge	Date	X			X
	DeliveryConductedBy	Select List	X			X
	DeliveryDateTime	Date	X	X	X	X
	DeliveryLocation	Select List	X			
	DeliveryMode	Select List	X	X		X
	DeliveryOutcome	Select List	X			X
	DischargeBy	Select List	X			
	EDDDate	Date		X	X	

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	Episiotomy	Yes No		X		
	FamilyPlanningMethod	Select List	X	X	X	X
	FeedingOption	Select List	X	X	X	X
	GestAge	DecimalTextBox	X	X	X	
	GestAgeAtBirth	DecimalTextBox			X	
	Gravidae	Select List	X	X		X
	InfantFeedingCounseling	Select List		X	X	X
	LabourDuration	Yes No		X		X
	LMPDate	Date		X		
	MalariaTreatment	Select List				X
	MotherAcceptHIVTesting	Select List		X		
	MotherConditionAfterDelivery	Select List	X	X		X
	MotherHIVPostTestCounseling	Yes No			X	
	MotherHIVPostTestCounselingDate	Date			X	
	MotherHIVPretestCounseling	Select List		X		
	MotherHIVPretestCounselingDate	Date			X	
	MotherHIVStatus	Select List				
	MotherHIVTestDate	Date			X	
	MotherHIVTestResult	Select List		X	X	X
	MotherKnownHIVStatus	Select List			X	X
	MotherPMTCTCode	Select List	X			
	MotherReferedToARV	Yes No			X	X
	OtherMedicalCondition	Select List				X
	Parity	Select List	X	X		X
	PartnerAge	Numeric		X		
	PartnerHIVPostTestCounseling	Yes No		X		
	PartnerHIVPretestCounseling	Yes No		X		X
	PartnerHIVTestAccept	Yes No	X			X
	PartnerHIVTestResult	Select List		X	X	X
	PartnerPMTCTCode	Select List	X			
	PartnerReferedForFollowUp	Yes No				
	PartnerReferedOrNot	Yes No				
	PartnerReferedTo	Select List		X		X
	PartnerReferedToOther	Text MultiLine		X		X

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	PlacentaComplete	Yes No				X
	Pregnant	Yes No				
	ReceivedITN	Yes No	X			X
	ReferedFrom	Select List				X
	SyphilisTestResult	Select List		X		X
	TBRxEndDate	Date			X	
	TBRxStartDate	Date			X	
	TBScreen	Yes No				X
	TBStatus	Select List	X			
	TestedForSyphilis	Yes No		X		
	VaginalTear	Yes No		X		
	Weight	DecimalTextBox	X		X	X

11.6.4.2 HIV Care Fields

This is the list of pre-defined fields for the HIV Care technical area.

	Pre-defined Field Name	Display Type	Uganda	Nigeria	Kenya
	AlternatePickUp	Date	X		
	ART Ended Reason	Select List	X	X	X
	ARTenddate	Date	X	X	X
	ARTTransferFrom	Select List	X	X	
	ARTTransferInDate	Date	X	X	
	ARVSideEffects	Select List	X	X	X
	ARV Why	Select List	X		
	Clinicteamleader	Text SingleLine	X		
	CohortMonth	Numeric	X		X
	CohortYear	Numeric	X		X
	Cotrimoxazole	Select List	X		X
	Cotrimoxazole Why	Multi Select			X
	CotrimoxazoleAdhere	Select List			X
	CTXStartedby2Months	Select List	X		
	DateOfAllergy	Date	X		X
	DateRestarted	Date	X	X	X
	DateTransferredIn	Date		X	
	District	Select List	X		

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	DrugAllergySpecify	Text MultiLine	X	X	X
	EDD	Date	X	X	X
	EligibleDate	Date	X	X	X
	Family Planning Method	Select List	X	X	X
	FamilyPlanningStatus	Select List	X	X	X
	Fluconazole	Select List			X
	FinalStatus	Select List	X		
	Fluconazole Why	Multi Select			X
	FluconazoleAdhere	Select List			X
	Gestation(wks)	DecimalTextBox	X		X
	HealthUnit	Select List	X		
	Height	DecimalTextBox		X	X
	Homebasedcareprovidedby	Text SingleLine	X		
	HospitalizedNumberofdays	Select List	X	X	X
	Initialadherencecouselingcompleted	Select List		X	
	LC1	Text SingleLine	X		
	NearestHealthCentre	Text MultiLine	X		
	New OIs, Other Medical Conditions	Select List	X		
	NearestSchool	Text MultiLine	X		
	NutritionalSupport	Select List	X		
	Parish	Select List	X		
	PatientReferred	Select List	X	X	X
	PatientContactsSubCounty	Select List	X		
	PatientSubCounty	Select List	X		
	PEP	Select List	X		
	PEPOther	Text SingleLine	X		
	PEPARVs	Text MultiLine	X		
	PEPStartDate	Date	X		X
	PEPWhere	Select List	X		
	PMTCTARVs	Text MultiLne	X		
	PMTCTOnly	Select list	X		
	PMTCTStartDate	Date	X		
	PMTCTWhere	Select List	X		
	Pregnancystatus	Select List	X	X	

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	Pregnant	Yes No	X	X	X
	PreviousARVs	Select List			X
	PriorART	Select List	X	X	X
	Regimen1	Regimen			X
	Regimen1_DateLastUsed	Date			X
	Regimen 2	Regimen			X
	Regimen2_DateLastUsed	Date			X
	Regimen 3	Regimen			X
	Regimen3_DateLastUsed	Date			X
	RelevantMedicalConditions	Text MultiLine	X		
	ScheduledAppointment	Numeric	X	X	
	SputumSent	Select List	X		
	SubCounty	Select List	X		
	TBScreening (same as TBStatus)	Select List			
	TBStatus	Select List	X	X	X
	TestLocation	Select List	X	X	X
	TreatmentSupportContact	Text SingleLine	X		
	TreatmentSupportName	Text SingleLine	X		
	TypeofReaction	Select List	X		
	Weight	DecimalTextBox	X	X	X
	WHOStage	Select List	X		X
	WhyEligible	Select List	X	X	X
	Willpickupmedications	Yes No	X		

11.6.5 Field Search and Filter

As the number of fields grow over time, it may be difficult to verify that a field exists. A search function has been added to help the user find the field you need. As well, you can filter the fields by technical area.

- Field Search
  1. Enter the part or all of the field text in the Field Name field
  2. Click the Search button
  3. The search results show all of the possible matches
  4. To display the entire list again, click on Show All

  In this example, ARV is the search term and every field that contains ARV within the field label displays.

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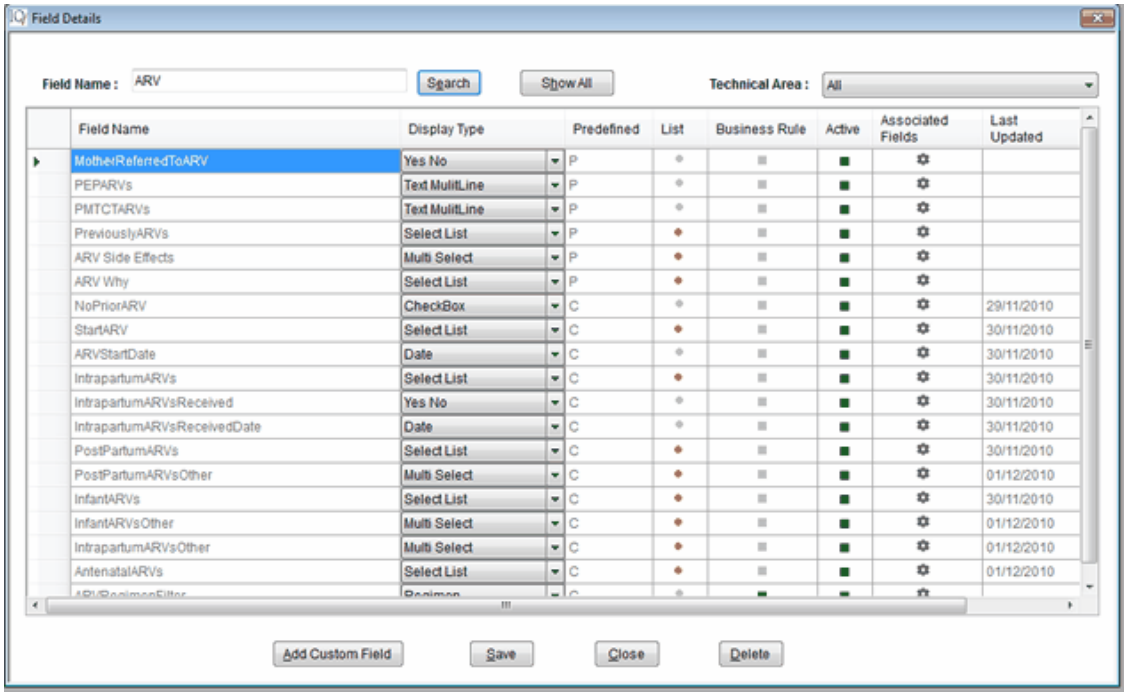
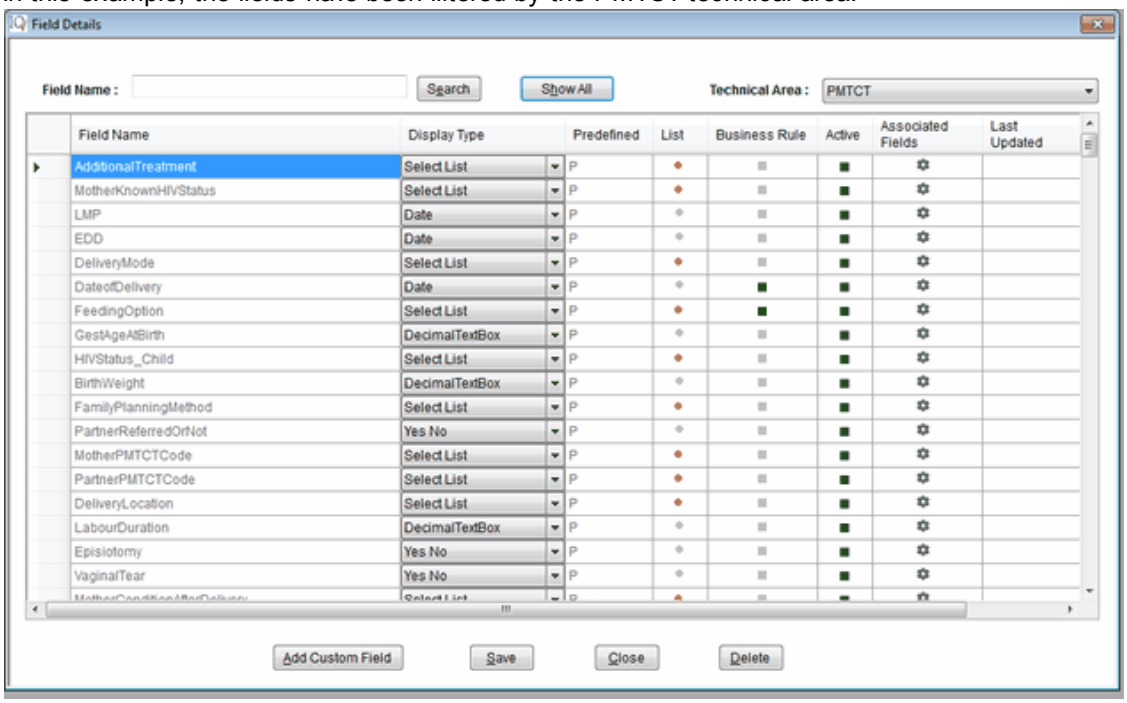


- Field Technical Area Filter

  The field list can be filtered by technical area. Select the technical area and the fields for the selected technical area display; the All option displays all of the fields.

  In this example, the fields have been filtered by the PMTCT technical area.



- Combined Field Search and Technical Area Filter

  You can combine searching for fields with a technical area filter.

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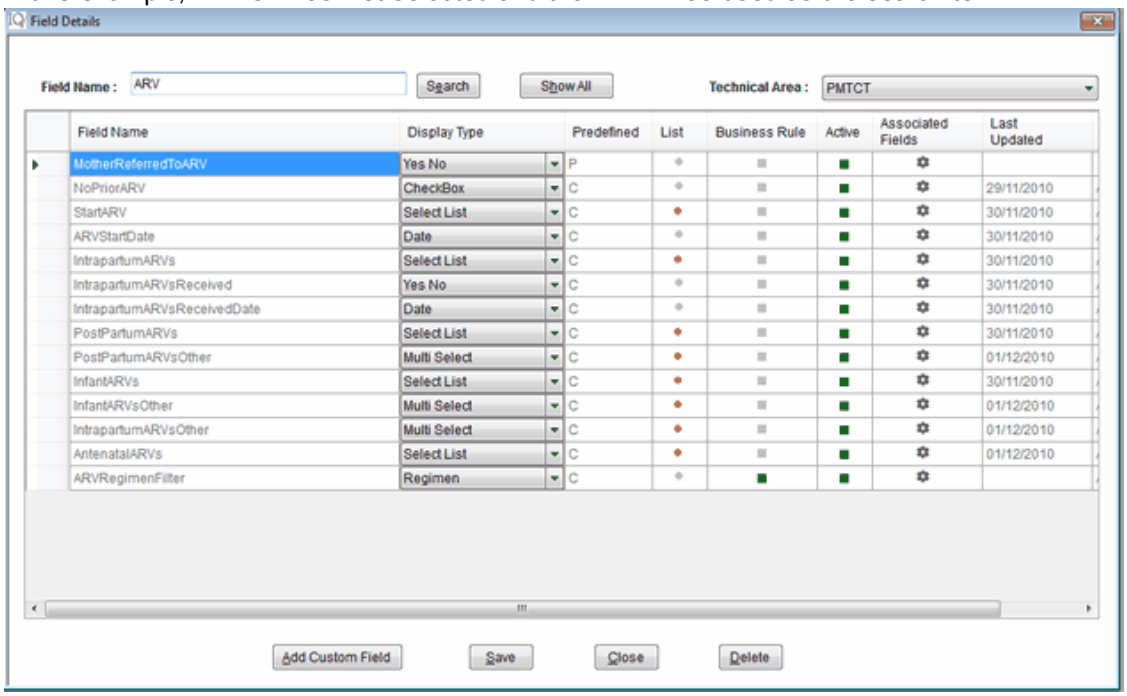
1. Select the technical area
2. Enter a search criteria and click the Search button

In this example, PMTCT was first selected and then ARV was used as the search term.



11.6.6 Create Custom Fields

If you do not find the field you need in the existing list of pre-defined fields or custom fields created in prior form building sessions, you can create your own fields.

To create a new field

1. Click Add Custom Field button and an empty row displays at the bottom of the pre-defined list.

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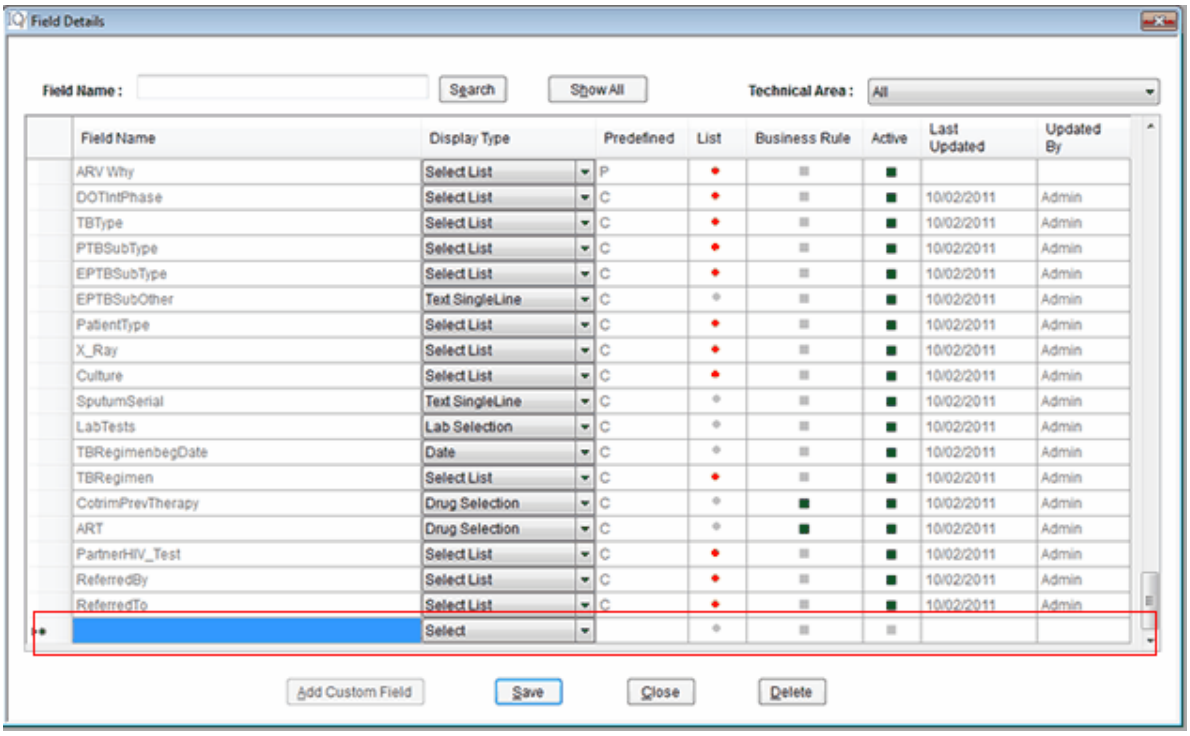
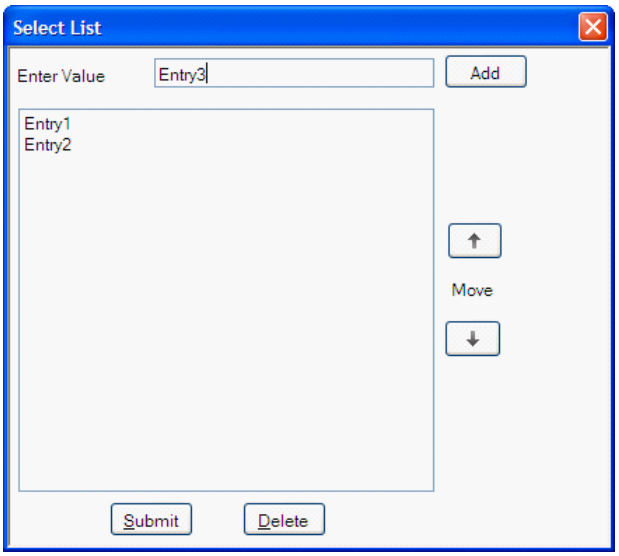


2. Click on the Field Name cell so that it turns white, and then type in the name of the field. Field names cannot have spaces in the name and IQCare automatically removes any spaces you attempt to add. Furthermore, most special characters cannot be used in the name; only underscore or dash may be used.
3. Tab or click into the Display Type cell; select the display type. If you select a Select or Multi-select list type, you must fill in an initial set of list entries. When you have entered all of the list entries, click on the Submit button.



4. Click on the Business Rule cell; a dialog box will display. Select the business rules you would like for this field and click submit. Or Cancel if you don't want to apply any business rules.
5. Click on the Save button to save the new field. Upon saving, the field will be re-ordered based on its

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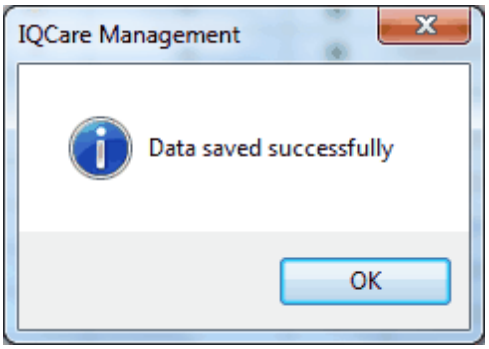
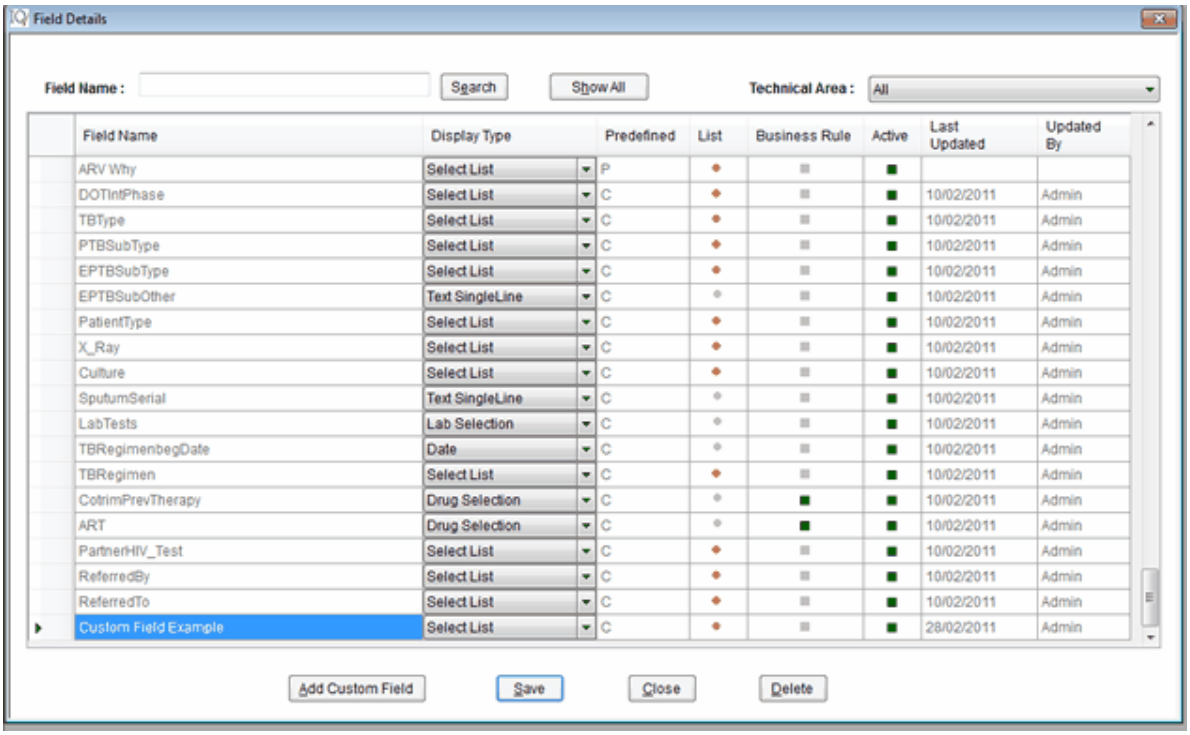
field name and saved in “Active” mode.





11.6.7 Update Custom Fields

For a custom field, the field name, display type, business rule, active toggle can be changed though the Form Builder. Select list entries must be changed via IQCare Customize Lists.

Change the Field Name

1. Find the field in the pre-defined field list
2. Click into the Field Name cell
3. Type the new name or modify the existing name
4. The name change automatically saves by the application

Change the Display Type

1. Find the field in the pre-defined field list
2. Click into the Display Type cell
3. The select list will open; select the new type. Upon selecting a new display type, a confirmation dialog box displays. Click Yes if you want to change the display type.
4. The Display Type change automatically saves by the application

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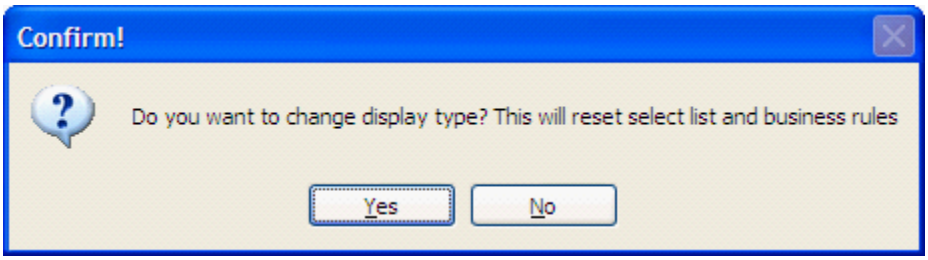

11.6.8 Add Business Rules

The business rules available in the form builder are based on the display type.

Add one or more business rules

1. Find the field in the Manage Fields view
2. Click into the Business Rule cell
3. A dialog will display with the business rule options. Check the rule options you want; Use the Conditional Fields button to configure select lists, yes/no and multi select list. When complete, click Submit.
4. Click the Save button to commit the change to the database. (Note: you need to save after each field change. IQCare does not batch up changes and change them all at once.)

Display Type	Used For	Business Rule Options
TextSingleLine	Single line text	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Data Quality Check Required Field
DecimalTextBox	Decimal number OR Single line text box	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Data Quality Check Min Value Max Value Number Decimal Required Field
Numeric	Integer number	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Data Quality Check Min Value Max Value Required Field
Select List	Select list	Active if current age >= min __ and < max __ years Active if female Active if male

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		Auto populate Data Quality Check Required Field Conditional Fields
Date	Date	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Date must be strictly greater than today's date Date must be strictly less then today's date Date must be strictly greater than date of birth Data Quality Check Required Field
Yes No	Yes No	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Data Quality Check Required Field Conditional Fields
Text MultiLine	Multi-line text box	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Required Field Data Quality Check
Checkbox	Check box	Required Field Data Quality Check
Multi Select List	Multi-select list	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Required Field Data Quality Check Conditional Fields
Regimen	Any kind of drug regimen with the display of A/B/C	Active if current age >= min __ and < max __ years Active if female Active if male Auto populate Data Quality Check Regimen (Drug type filter) Required Field
Drug Selection	Drug selection within a form	Filtered Drug Button Required Field
Lab Selection	Lab selection within a form	Active if current age >= min __ and < max __ years Active if female Active if male Lab selection

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		Required Field

11.6.9 Update Business Rules

Change the business rule

1. Find the field in the pre-defined field list
2. Click into the Business Rule cell
3. A dialog will display with your prior business rule selection. Change the business rule(s) selected or user the Conditional Fields button to see the conditional configuration previously set for select lists, yes/no and multi select list. When complete, click Submit.
4. Click the Save button to commit the change to the database. (Note: you need to save after each field change. IQCare does not batch up changes and change them all at once.)

11.6.10 Inactivate/Delete a Field

Inactivate a pre-defined field

Inactivating a field removes the field from the list of fields available for selection when building or updating a form. The field still exists in the database and may be used available in forms prior to being inactivated.

1. Find the field in the pre-defined field list
2. Click into the Active cell
3. A dialog will display confirming that you want to change the status of the field
4. The Active/Inactive change automatically saves by the application

Deleting a field means that the field is deleted in the database. If a field has not been used in a form, it can be deleted from the pre-defined list of fields. However, if it is used in one or more forms (in any form state) then it can not be deleted, only inactivated. Only custom fields can be deleted.

1. Find the field in the pre-defined field list
2. Click into the Delete button
3. A dialog will display confirming that you want to delete the field (if it is not already in use) displays.
4. Click the Yes button to delete.
5. The field will be removed from the list.

11.6.11 Add Conditional Fields

The conditional display of fields is a feature that allows you to configure select lists, multi-select lists and yes/no type fields so that conditional on a selected list entry or yes/no, one or more associated fields display in IQCare forms. For example, supposed in a select list there is an entry called "Other (specify)". Upon selecting the Other (specify) select list option, another field such as a text field may become active and available for data to be entered into the field. The benefit of this kind of feature is only associated fields for specific select list entries will be active upon selection, reducing data entry errors.

Facts About Conditional Fields

- Select lists, multi-select lists and yes/no field types can be configured to have conditional display of fields
- Any number of fields can selected as an associated field with a list entry
- Any field type can be selected as an associated field with a list entry
- In IQCare, all fields associated with select lists that are configured with conditional fields are visible. When an entry option is selected, associated fields become active; fields that have not been

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configured to be associated with a select list entry option become inactive.

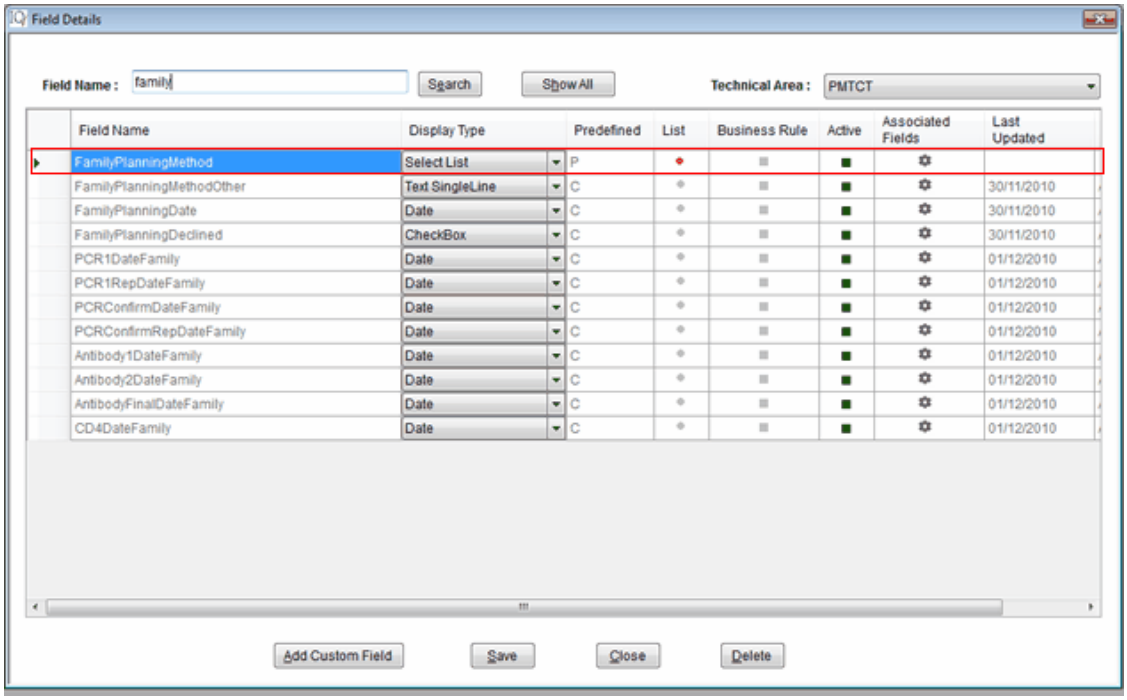
- One or more of the same fields associated with a conditional field. For example, if the primary field select list has entries A and B; When A is selected - the fields D and E become active; When B is selected - the field D and F become active. Field D is common to both primary select list entries A and B. This is allowed because data for field D can only be entered once on the form.
- If you have configured a field to be associated with another field, the associated field cannot also be added to a form as a separate field. For example, if you have a field "A" which is associated with field "B" (configured in Manage Fields), you cannot put field "B" on the form. This would actually put the field on the form two times which is not allowed.

Add Conditional Fields

1. Find the field (select list, multi-select list or yes/no field) that you want to configure. Note that this can be a pre-defined or custom field.

In this example, there is an "Other" family planning method in the select list. We want to associate the text field "FamilyPlanningMethodOther" with the select list option "Other".

2. Click on the gray flower icon in the Associated Fields column



3. Click on the Conditional Fields button

Here is the select list for Family Planning Option

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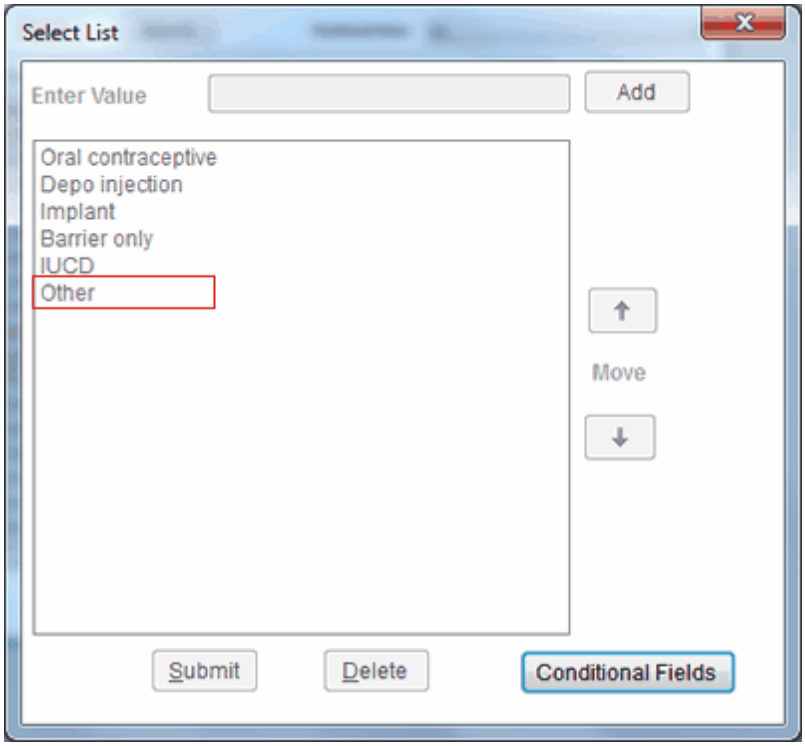
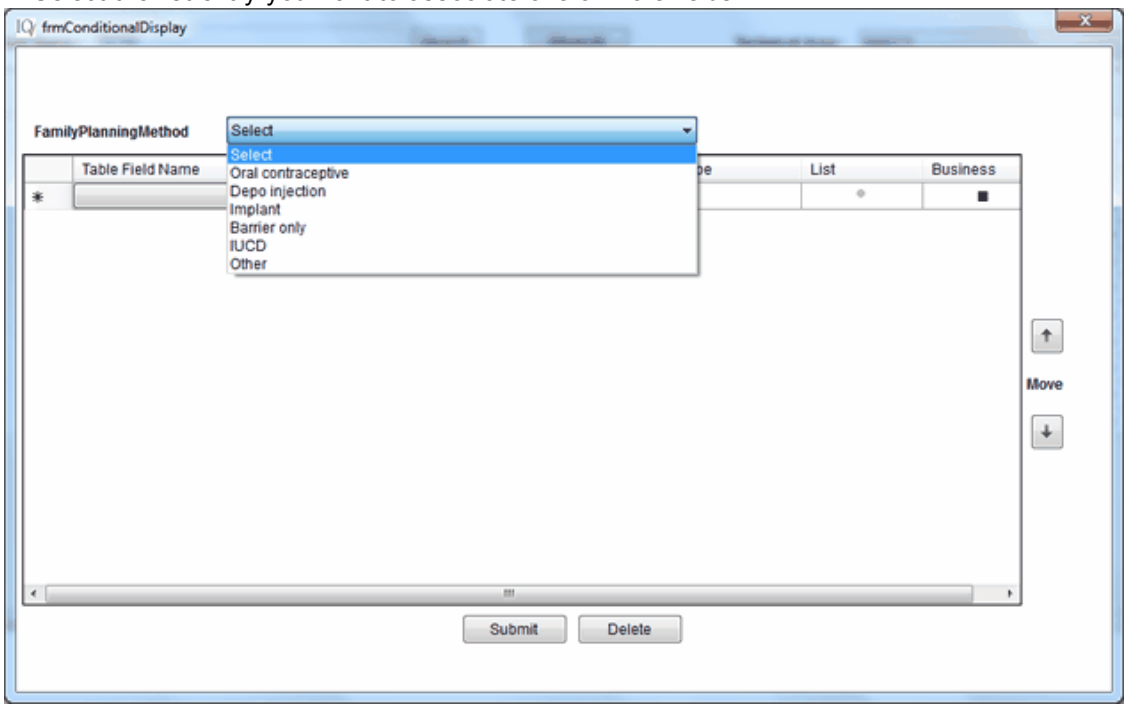


4. Select the list entry you want to associate one or more fields



5. Using the field select list, find and select the field you would like to associate with the select list field entry "Other". You can any number of fields.

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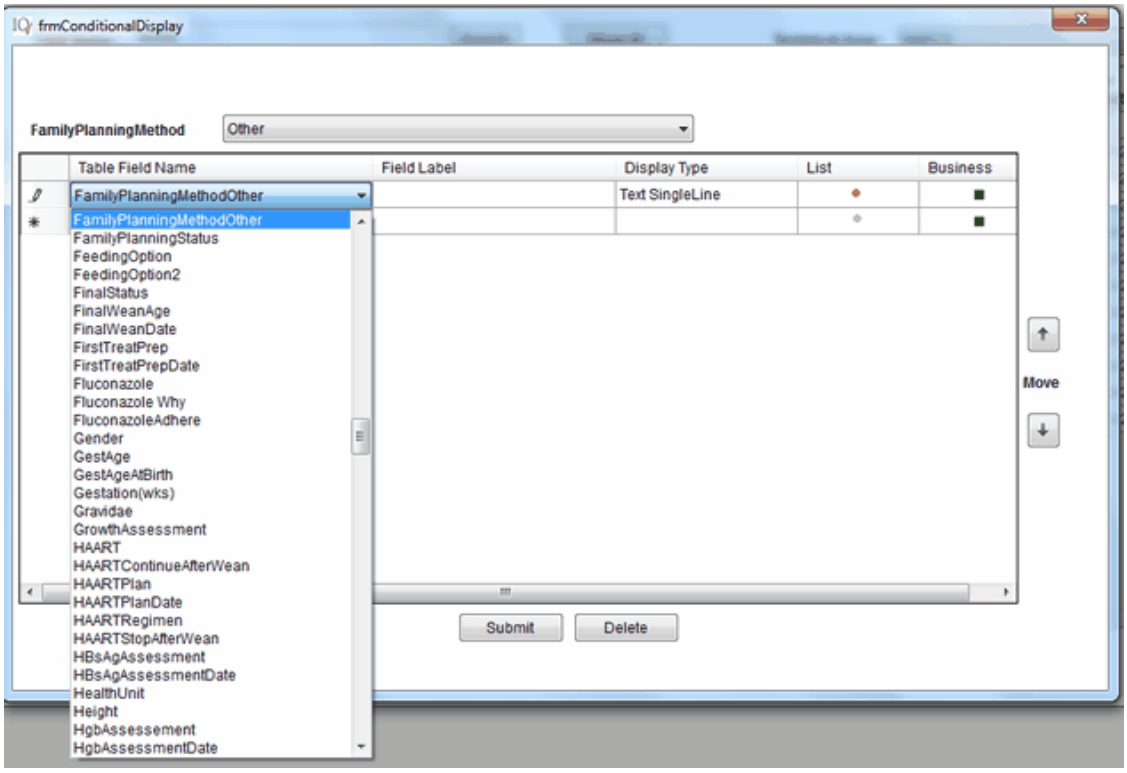
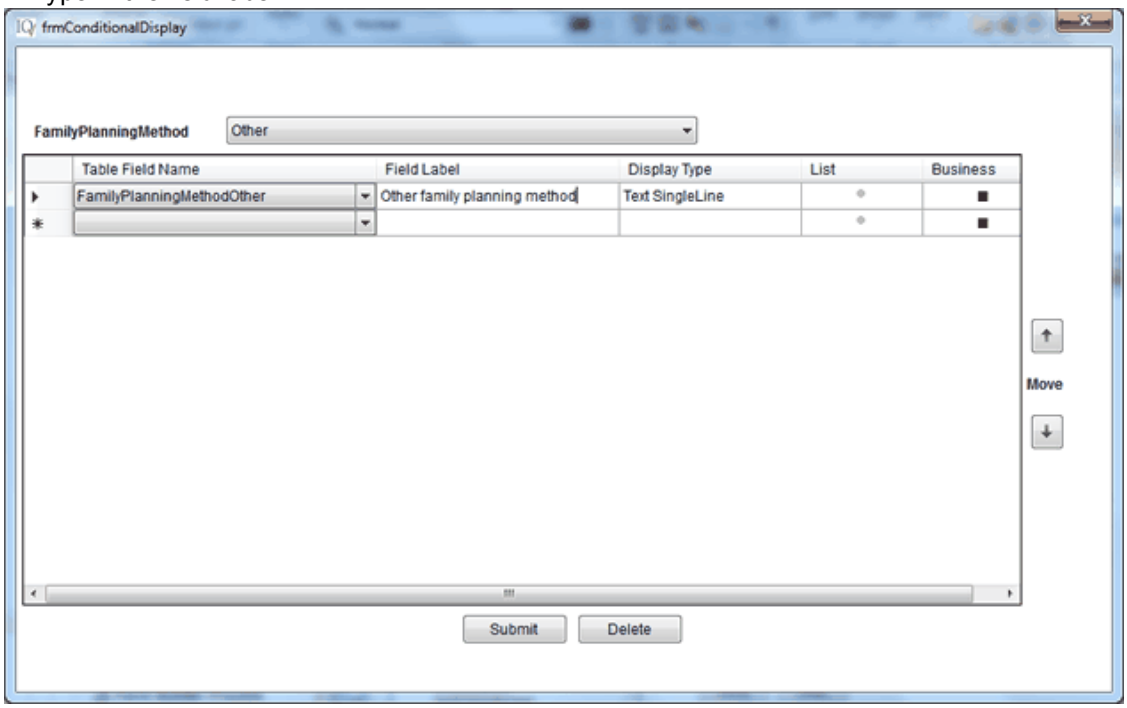


6. Type in the field label



7. Repeat this process by selecting another select list entry for the list you are configuring and adding other conditional fields. You can review your work by returning to any list entry and review the fields that have been configured.
8. Click the Submit button to save this configuration

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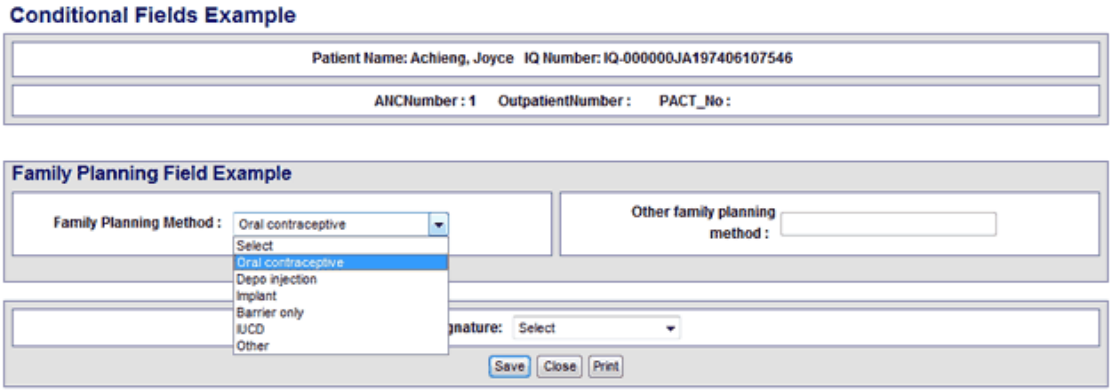
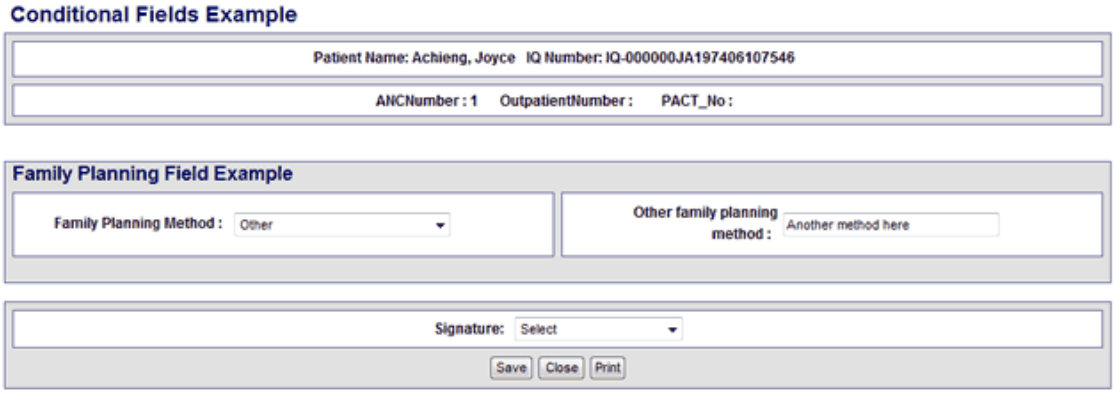
9. Once back in the Manage Fields dialog you must click the Save button to save your work.

Here is an example of how the display works in IQCare. The field Other family planning method only becomes active if "Other" is selected in the Family Planning Method select list.



With the selection of "Other" the field Other family planning method becomes active and you enter text in the field.



Conditional Fields Associated with One or More of the Same Fields

In this example TBType is associated with P, EP and P plus EP. (This example is starting from the configuration step after you click on the conditional fields button above in Step 3.)

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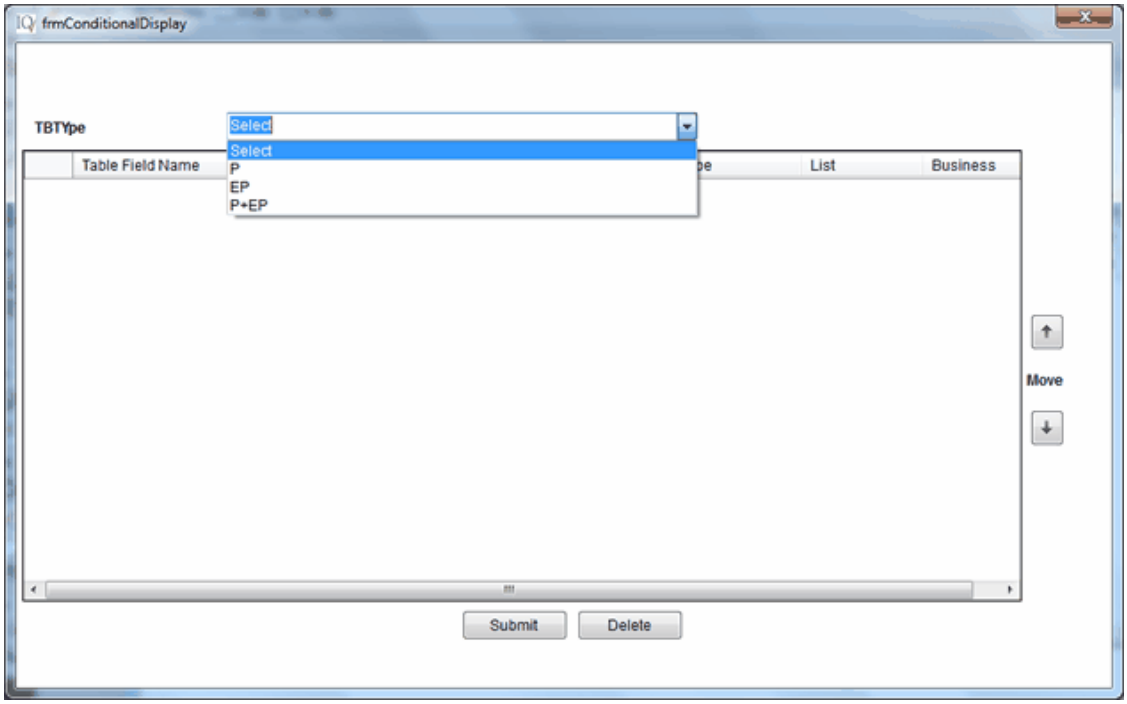
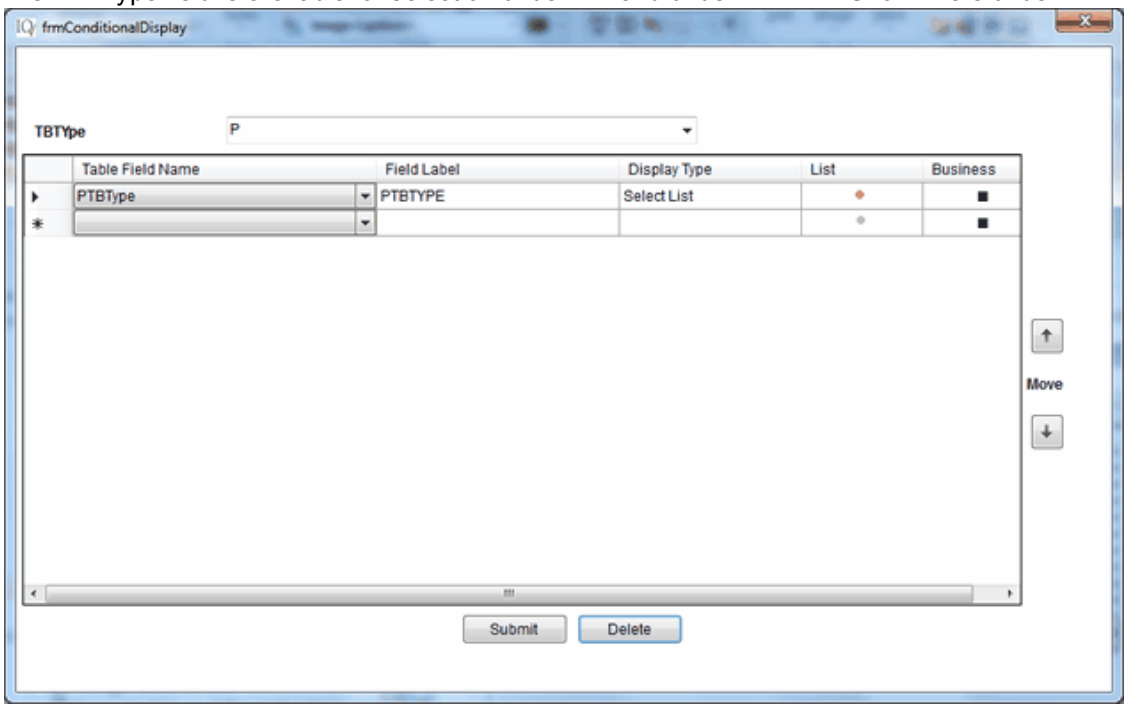


The PTBType field is available for selection under "P" and under "P+EP". Shown here under "P".



Shown here under "P+EP". A field can be assigned to more than one select list entry when configuring conditional fields.

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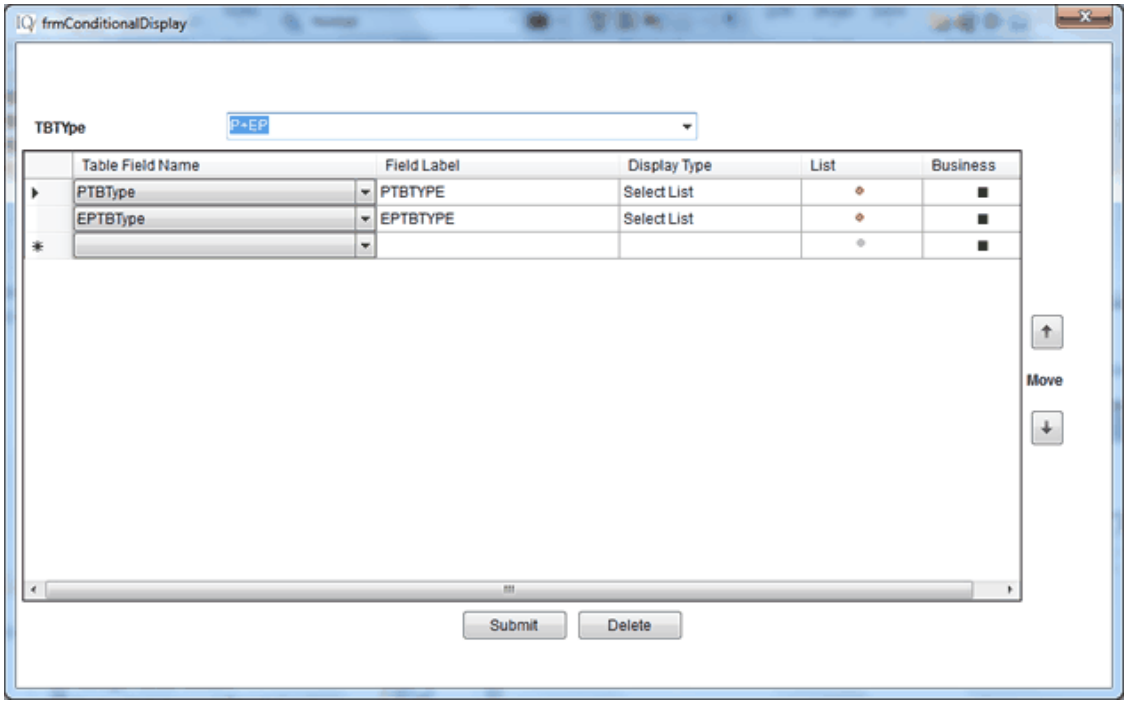

11.6.12 Update/Remove Conditional Fields

Facts About Updating Conditional Fields

- For an existing field that has been associated with a select list entry, you can only change the label text; you can not change/switch out one field for another
- If you want to replace a previously selected field with a new one, you must first delete the existing field and then add in the new field
- You can add new fields to an existing set of previously associated fields

Add Conditional Fields

1. In Manage Fields, find the field you want to change
2. Click on the Associated Fields icon
3. Click on the Conditional Fields button in the select list dialog box
4. Select the select list entry that you want to associate more fields with

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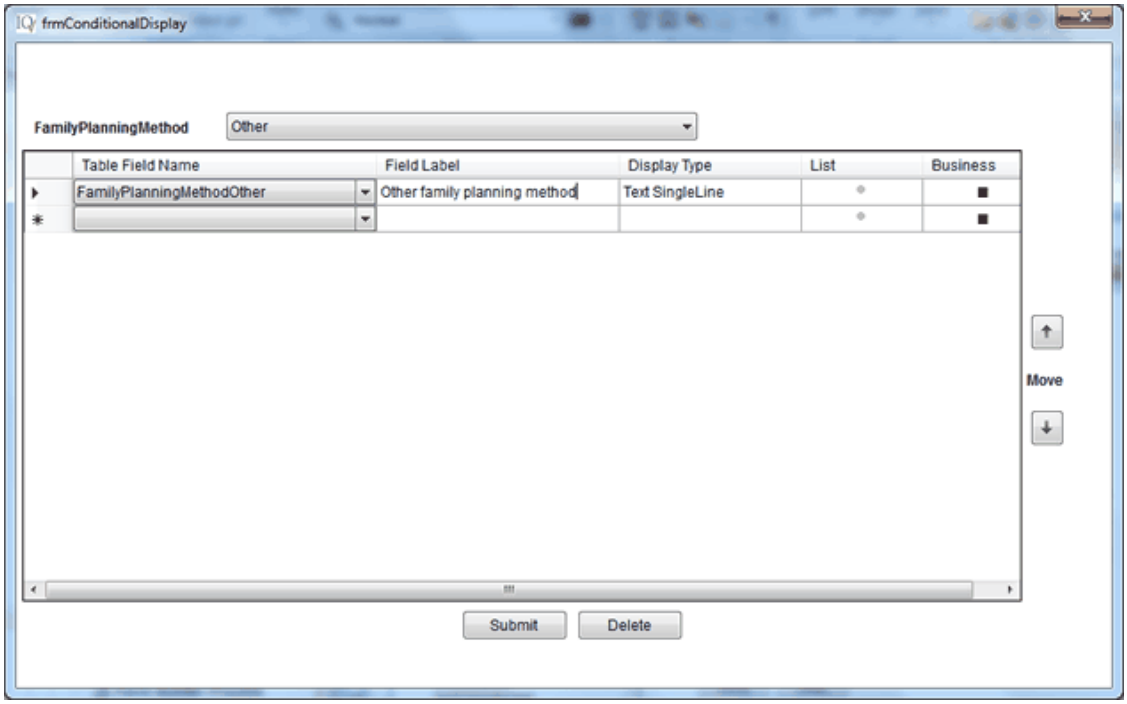
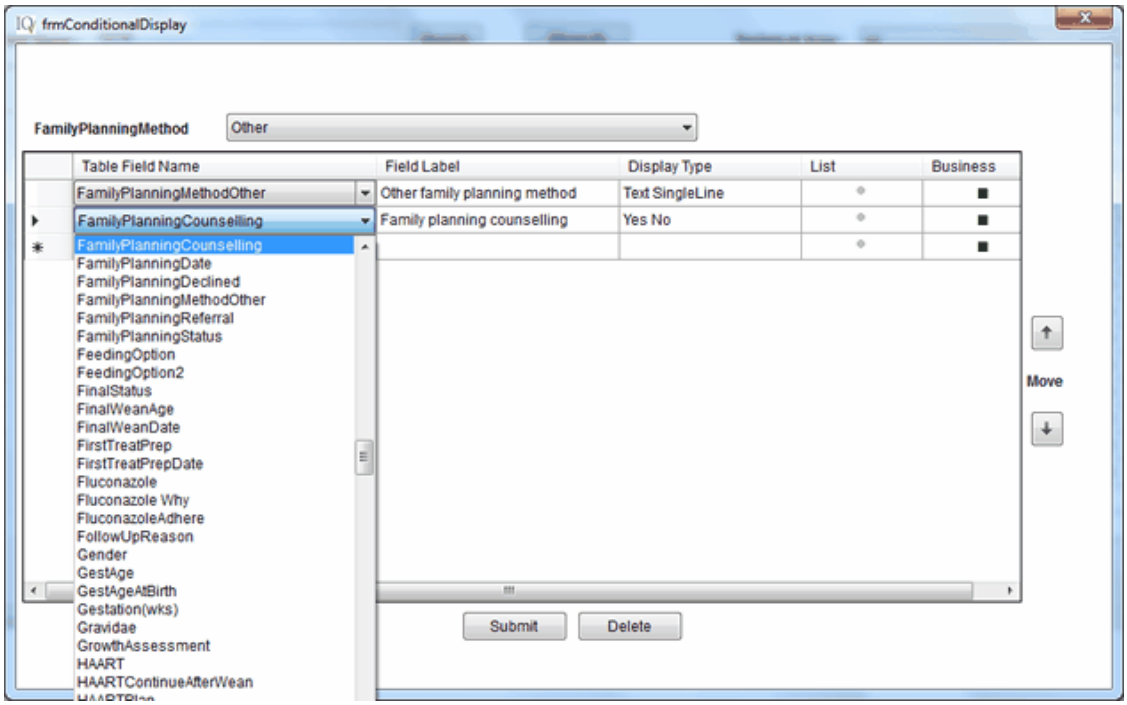


5. Using the select list select additional fields and type in the field labels
6. Click to Submit the updates



7. Click Save to save your work; remember you much click the save button in order to save all of your work.

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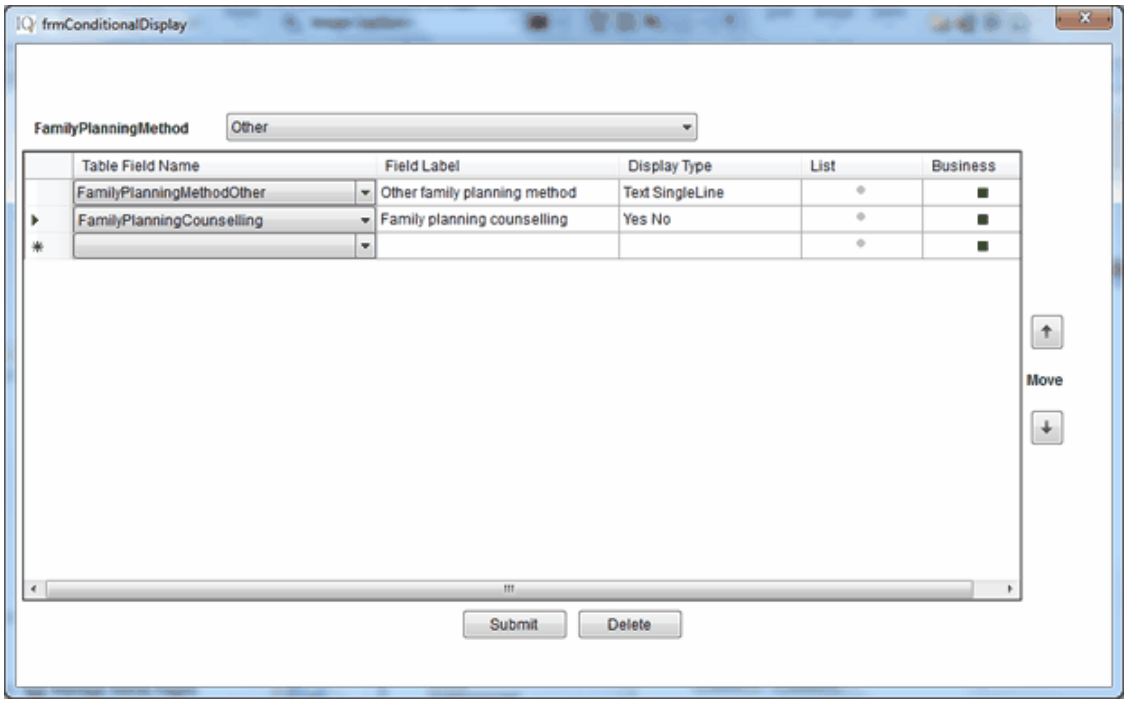
Update a Conditional Field Label

1. In Manage Fields, find the field you want to change
2. Click on the Associated Fields icon
3. Click on the Conditional Fields button in the select list dialog box
4. Select the select list entry that you want to update
5. For the associate field, update the label
6. Click to Submit the update
7. Click to Save to save your work

Remove or Replace a Conditional Field

1. In Manage Fields, find the field you want to change
2. Click on the Associated Fields icon
3. Click on the Conditional Fields button in the select list dialog box
4. Select the select list entry that you want to update



5. Highlight the field you want to remove

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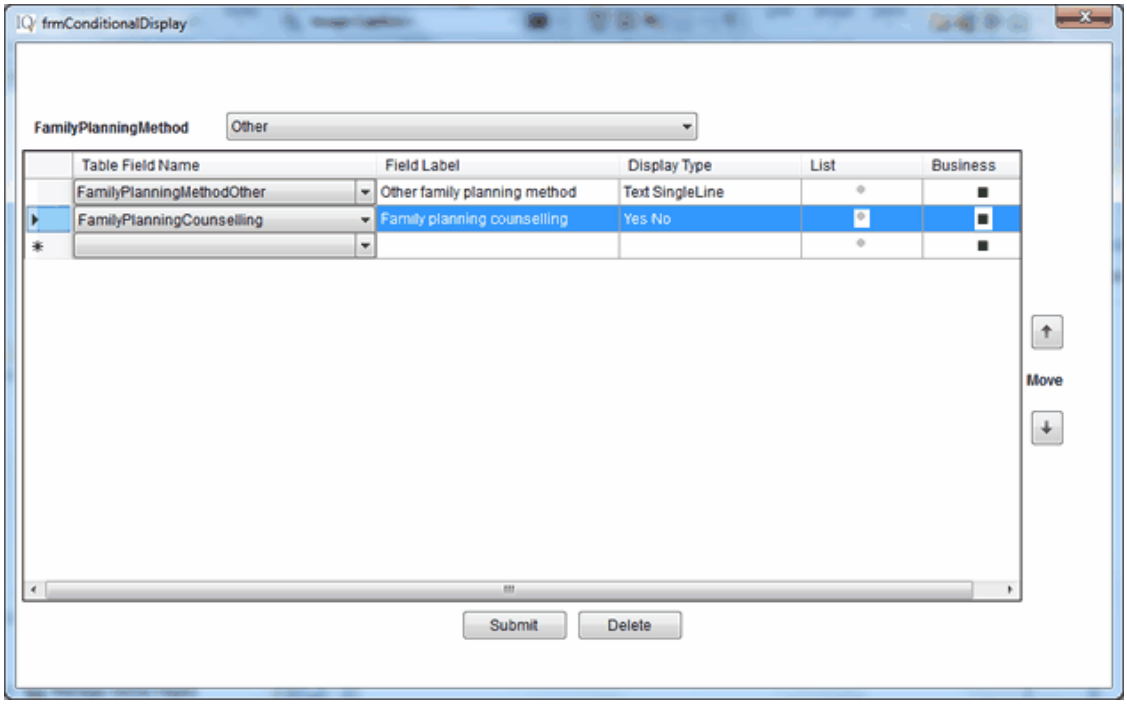

6. Click the delete button to remove the field
7. Using the field select list, select another field and type in a label
8. Click submit to save the update
9. Click Save to save your work

11.7 Manage Forms

IQCare Form Builder provides a lot of functionality for creating clinical forms. Here is a high level list of features:

Managing Form Sets

- Add dynamic forms to the HIV Care Static form set.
- Add static pharmacy, lab and Follow up Education with a dynamic custom set of forms.
- Assign forms to one or more technical area/program
- Configure forms for single or multiple visits
- Conditional display of data fields

Managing Data

- Add any type of data to a form, including specialized types for drugs, labs and regimens
- Add business rules for enhanced data quality
- Use data fields from pre-defined data sets for PMTCT, ART and TB

Share Forms Across Your Organization

- Export/Import forms

11.7.1 Form Builder Process

There is a process for building forms and making them visible in IQCare. Forms are in one of three states: In progress, Published or Unpublished.

In Progress Forms

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In Progress forms are forms that are being created from scratch. These forms are editable and not visible in IQCare. In Progress forms can be deleted.

Published Forms

When you are ready to use a form in IQCare, you will “publish” the form which will make it visible under the PMTCT “Create New Form” navigation at the patient level. Once a form is published, it can not be edited within the Form Builder.

Unpublished Forms

If you need to make updates to a published form or you do not want the form be used anymore, you “unpublish” the form which removes it from being available in IQCare. A form in the “Unpublished” state is editable Form Builder. Updates can be made on unpublished forms and they can be re-published. Forms that have been published but no data have ever been entered in the form in IQCare (a form has never been saved) can be unpublished and deleted. However, forms that have been published and data saved to the form can not be deleted. They stay in the unpublished state forever.

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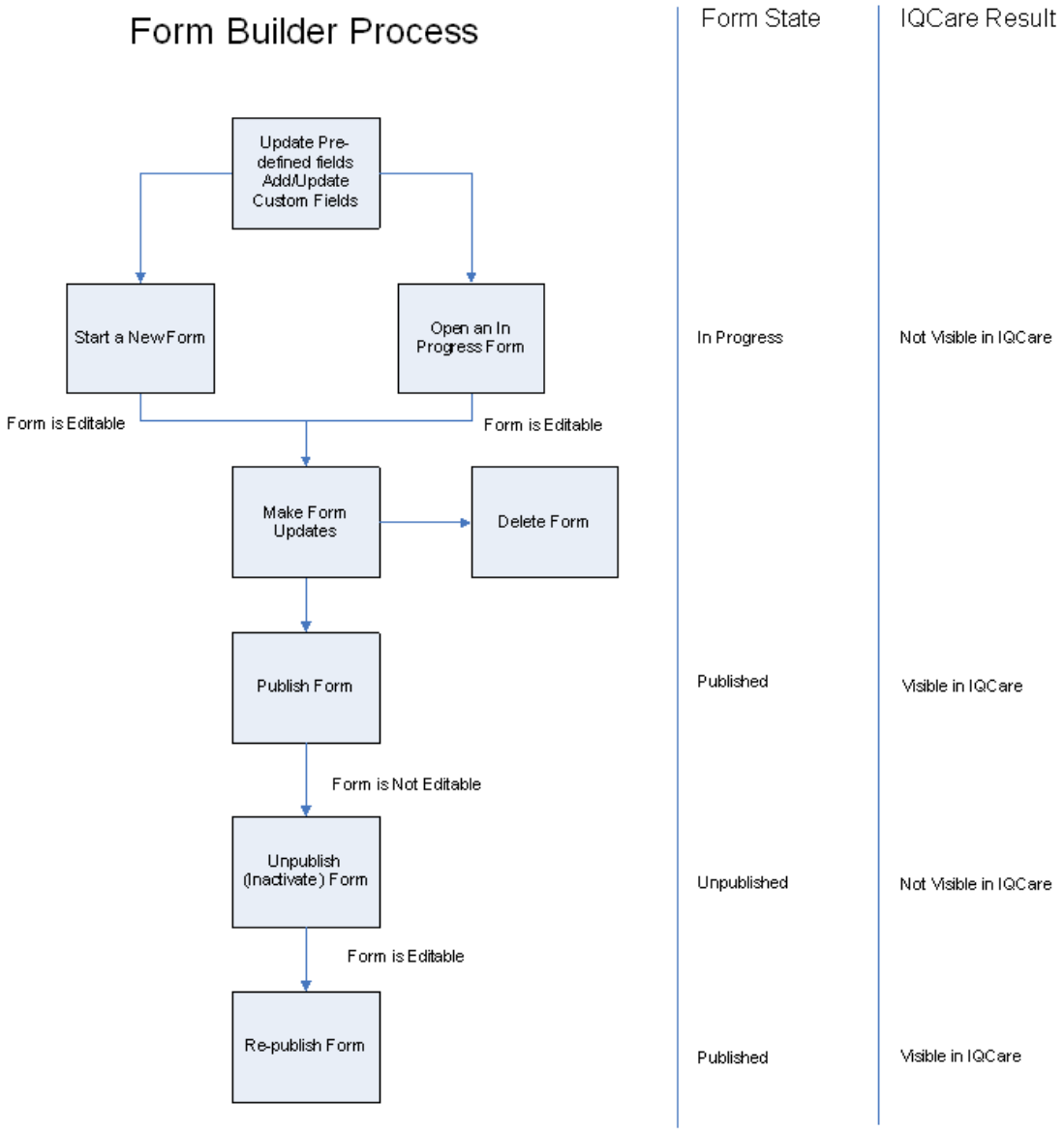

11.7.2 Manage Forms Window

Forms are first created and then published so that they become visible in IQCare. A form that is no long required or needs to be updated is unpublished.

From within the Manage Forms Window, you can:

Do these <u>form building</u> activities:

1. Create a new form – brings up a blank form
2. Edit an existing form – opens an In Progress or Unpublished form
3. Preview an existing form – previews all forms regardless of state
4. Delete a form – Deletes an In Progress or Unpublished form with no data
5. Close – Closes the Manage Forms Window

Do these <u>IQCare publishing</u> activities:

1. Create/update a form – In progress are highlighted in pink – with a diamond shape

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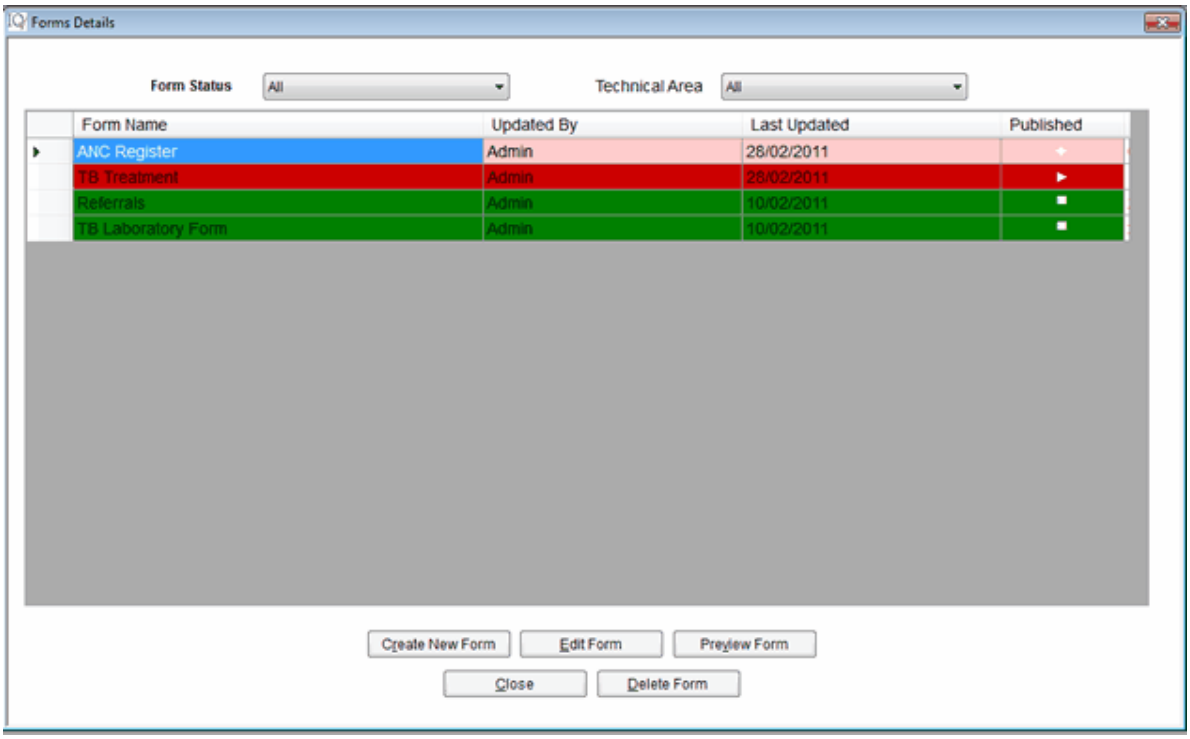
2. Publish a form -- Published forms are highlighted in green – with a square shape
3. Unpublish a form – Unpublished forms are highlighted in red – with a triangle shape

Do these filtering activities:

1. Filter the forms by form publishing status
2. Filter the forms by technical area



11.7.3 Forms Used Across Different Countries

Facts about creating forms that will be shared across different countries:

- The currency selected in the Facility Setup is what drives the country selection for IQCare and subsequently, any forms you create within IQCare.
- Forms are created on a country basis and can be modified (if user access is given) at the facility level
- The same process can be used with different countries
- You can create forms for different countries in the same (blank) database, each with different currencies selected
- The ability to create and publish forms can only be done if the user has the right access. (Form Builder is checked in the Admin section of the User Group Administration for a user group.)

11.7.4 Create New Form

When creating a new form, IQCare provides a number of different controls and options. Please refer to this screen shot for the information below.

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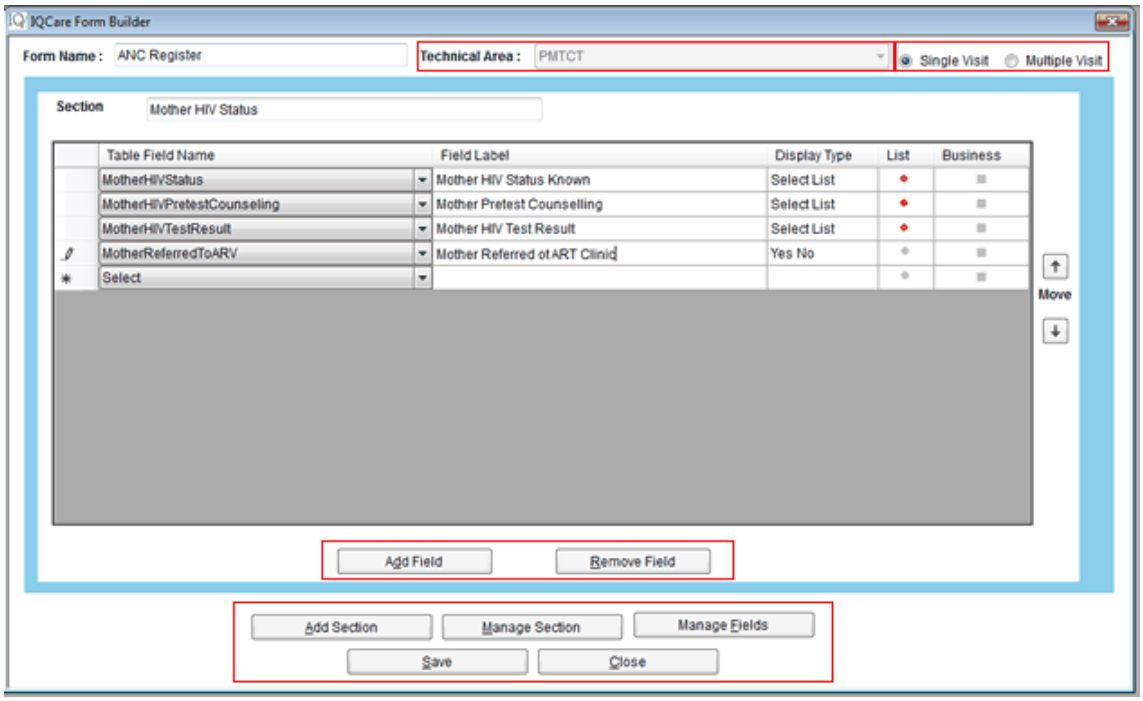

- Technical Area
  - Every form must be associated with a technical area.
  - The technical area select list entries reflect the list of technical areas that have been published in the Technical Area section of IQCare Management.
  - A form cannot have more than one technical area. If a form is used in more than one technical area, you must recreate the form with the new technical area.
  - Once you have saved your new form, the technical area for that form cannot be changed. The technical area select list is disabled. If you make a mistake you should move to Manage Forms, remove the form and then start again with the correct technical area selected.

.

- Single and Multi Entry Forms

  Every form is a single or multi entry form. This option is selected at the top of each form.

  Single Entry Form
  A form that has many instances and where you enter information on a per visit basis. An example of this kind of form is an ART Follow up form. The visit date and signature fields are automatically added to the form when displayed in IQCare. To view a saved single visit form, you can access it from View Existing Forms; To get a blank form, use the Create New Form menu option.

  Multi Entry Form:
  A form that has one instance and where you would enter information across different dates. An example of this kind of form is the summary information on an ART Card face page, such as the Initial Evaluation or the Prior ARV History. These forms do not have a visit date at the top of the form. The first saved date is the date that is designated for the form in the database. This date is displayed in the View Existing Form page in IQCare.

  In a multi entry type of form you can access the form at any time from the Create Forms menu in IQCare. The first time the form is accessed, all of the form fields are empty. Once the form has

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been saved, you can access the saved form either from View Existing Form or from the Create New Form menu.

- Form Controls

Field Controls

Add field - adds a row to the field block within the section you are working
Remove field - removes the selected row from the field block within the section you are working
Move field - moves the location of the selected row up (upward arrow) or down (downward arrow)

Section Controls

Add section - adds a section to the form
Manage section - allows you to re-arrange or remove sections
For more information about sections see Add/Manage Sections

Manage Fields - brings up the Manage Field dialog. This dialog displays on top of the Manage Forms dialog. When you have completed managing fields, "x" out of the Manage Fields dialog to see the in progress Manage Forms dialog. When you move from from building activities to managing fields, the system does not automatically save your in-progress form.
Close - Closes the Manage Fields dialog without saving your work

- Other Facts About Creating Forms
  - You only have one instance of a field on a form. That is, you cannot have a field in one section and the same field in another section.
  - If you have configured a field to be associated with another field, the associated field cannot be added to the form as a separate field. For example, if you have a field "A" which is associated with field "B" (configured in Manage Fields), you cannot put field "B" on the form. This would actually put the field on the form two times which is not allowed.
  - Special characters such as apostrophe, back slash, star, etc can not be used in the section label or field labels.
  - The Preview function will give you an idea of how the form will look in IQCare – how the fields will be laid out. The labels will be formatted better in IQCare.
  - For Custom Fields you can see but not change the items in a list nor can you change the business rule selection when building a form. Click on the orange dot or green square and the dialog box displays but is inactive. Changes to select lists must be done in IQCare, via customize lists; changes to business rules must be done in Manage Fields.

- **Create New Form**

1. Click on the Create New Form button
2. Enter the form name
3. Select the Technical Area
4. Select the Single visit or Multiple visit option
5. Click Add Section and enter a section name (required)
6. Click Add Field and an empty field will display
7. Click into the Table Field Name cell and scroll down to find the pre-defined field you want.
8. Enter the label that will appear on the form, next to this field
9. Repeat adding fields for this section.

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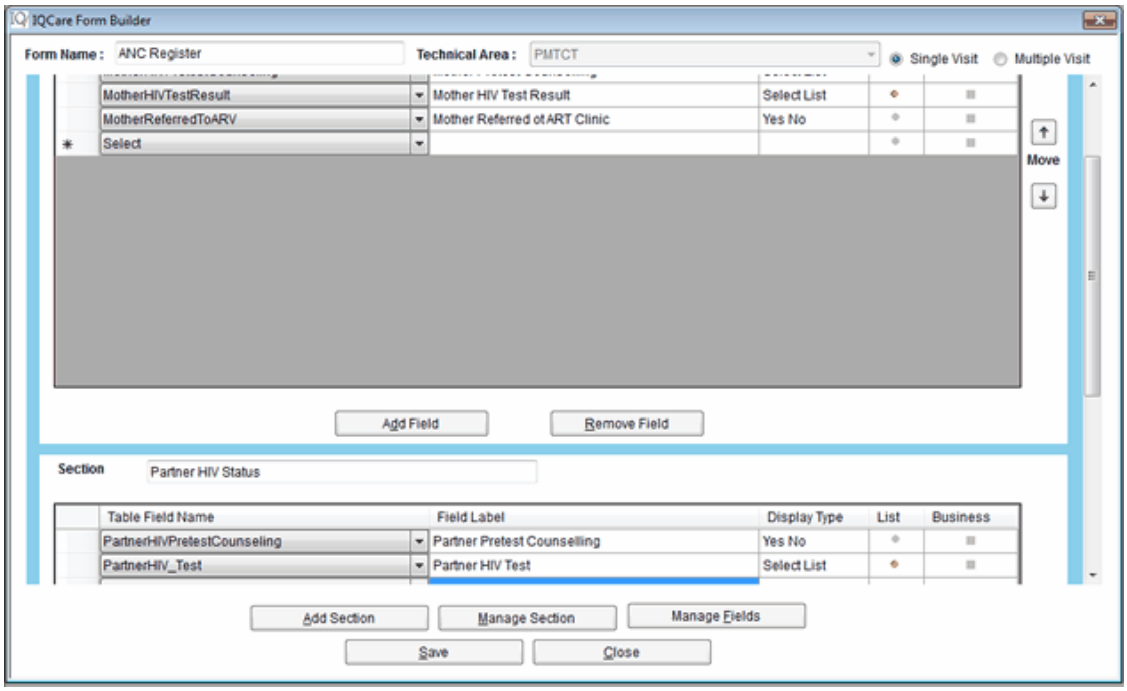
11.7.5 Add/Manage Sections

Add One or More Sections

1. Click on Add Section and an empty section displays
2. Enter the section name; Some special character can be used in the section name namely: ampersand, left and right parentheses, dash, underscore, question mark, comma and single quote. All other special characters cannot be used and IQCare will not let you type these prohibited characters.
3. Add one or more fields and enter the field display label. As with the section name, only a specific set of special characters mentioned above can be used in the display label.
4. Note that to see other sections in the form; you use the scroll bar at the left of the screen.
5. Continue to add sections and fields.
6. To preview your work, click the Preview button.
7. Click the Save button to save your work.



Move a Field In a Section

1. Find the section and field you want to move/re-arrange.
2. Use the Move buttons to move the field up and down

Remove a field In a Section

1. Find the section and field you want to remove
2. Highlight the name of the field
3. Click the Remove Field button

Manage Section

Once you have added a section, you can re-arrange or remove a section; to do that you use the Manage Section feature.

1. Click on the Manage Section button
2. Highlight the section name you want to move or remove

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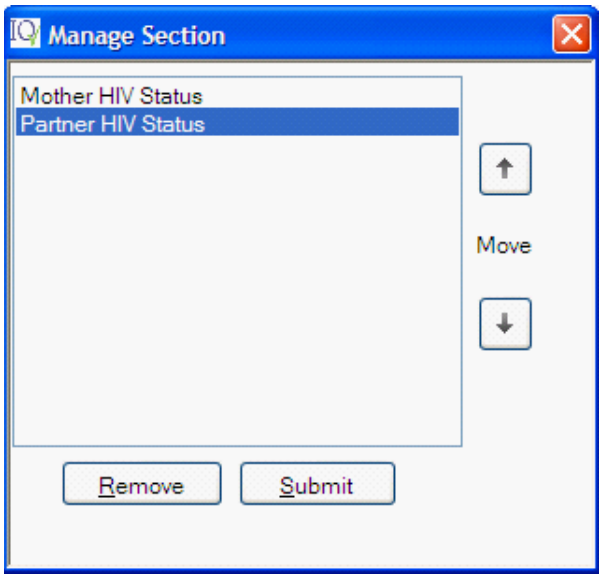

3. Use the move buttons to move the section to the new location and click Submit
4. OR use the Remove button to remove the section altogether

11.7.6 Delete a Form

1. Move to the Manage Form window
2. Select the form you want to delete
3. Click the Delete Form button
4. If the form can deleted, the system will ask you to confirm the deletion; if the form can not be deleted, then the system will display an error message.

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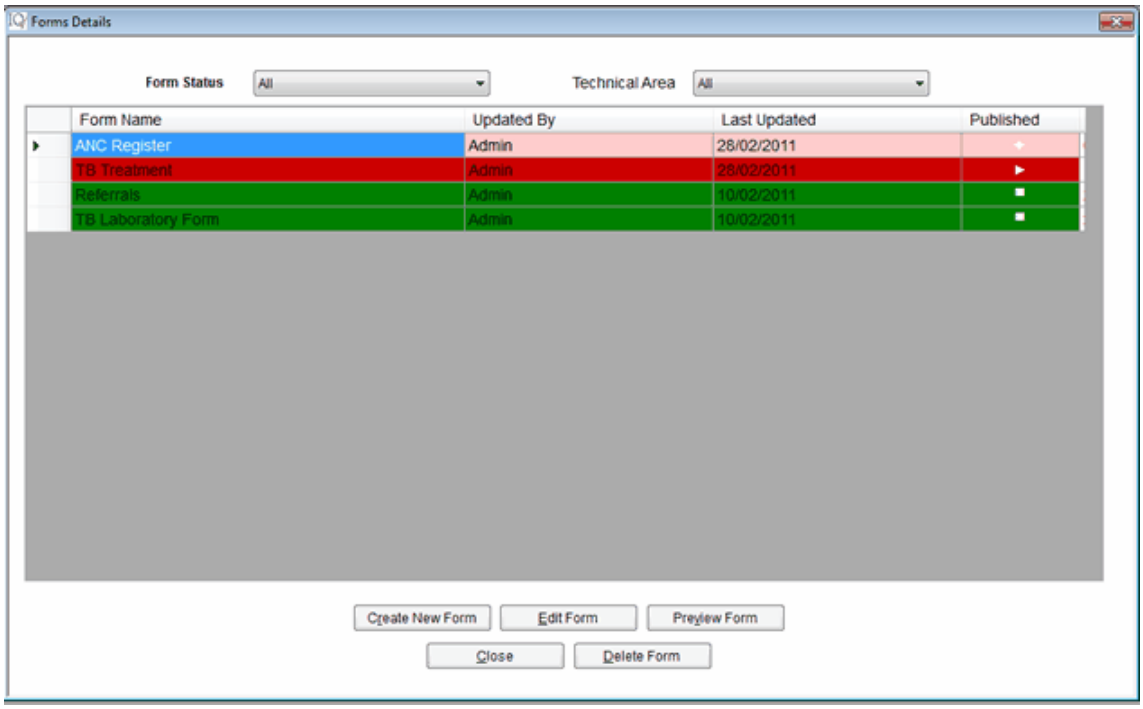

11.7.7 Publish Forms

When a form changes state, the form row in the Manage Form window will change

- In progress are highlighted in pink – with a diamond shape
- Published forms are highlighted in green – with a square shape
- Unpublished forms are highlighted in red – with a triangle shape

Publish or Unpublish a Form

1. Move to the Manage Form window
2. Select the form you want to publish or unpublish
3. Click into the Publish cell for the selected form
4. Confirm that the form should be published
5. Go to DB Operations and click Refresh System Cache to update IQCare; alternatively, go to Administration/Refresh System Cache to update the cache.

11.7.8 Import/Export Forms

IQCare Management provides a feature that allows you to share your forms and home page queries with others. Through the export function, IQCare creates an .xml type file. This file is then used to import the forms or home pages from one IQCare database to another database. You can import forms and home pages from different countries, technical areas and forms.

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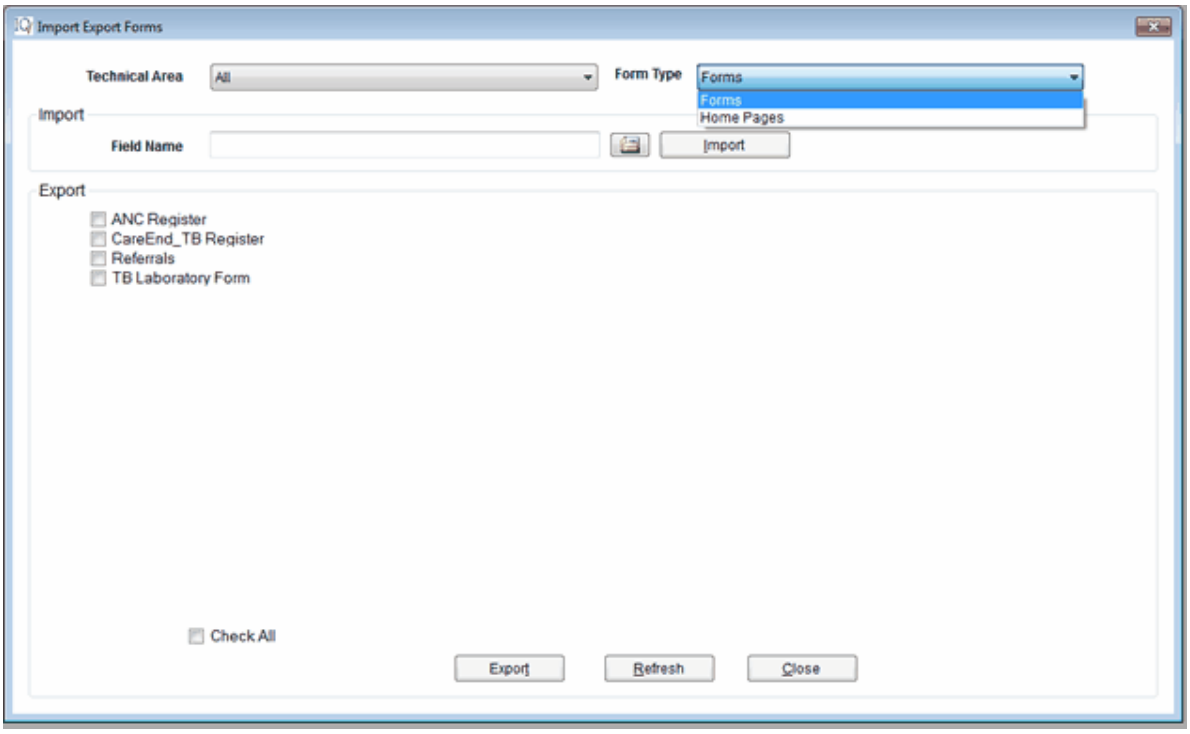

- Export forms or home pages

1. Create your forms; the technical area that is associate with a form stays with the form.
2. Use the technical area select list to filter the list of forms or home pages available to export
3. Select forms or home pages
4. Select the forms or home pages you want to export by checking on or all.
5. Click the Export button
6. Save the files to a location on your computer or thumb drive

- Import forms and home pages

Preparation steps for importing forms
In order for the forms or home page import to work correctly, you first make sure that the technical area of the forms you are going to import is configured in IQCare Management. To find the technical area name, open the .xml export file in Notepad and search for the <ModuleName> tag. Note the name of the technical area and move to IQCare Management and create the area.

1. Click on the file icon to browse for the .xml file that was generated by IQCare. Note that you can only import forms and home pages from the same version of IQCare that you currently are using.
2. Click on the import button
3. The system will give you confirmation of a successful import.

11.7.9 PMTCT Form Naming Convention

In order to identify patients receiving ANC, Labor and Delivery and Post Natal services, a form naming convention has been adopted. This naming convention is used by IQCare to know which phase the mother is currently in. The PMTCT predefine reports are separated by these phases and IQCare uses this information to correctly calculate the reporting indicators.

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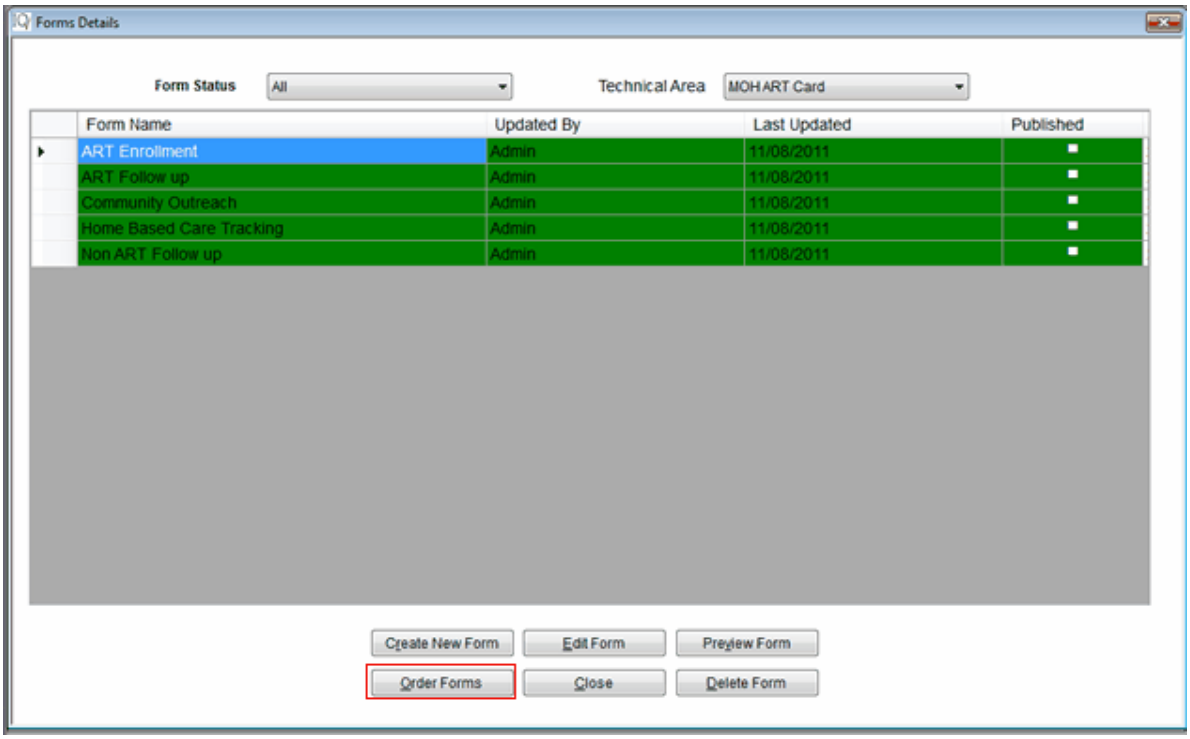
- If the form name has “ANC” in it - then it's an Ante Natal form
  - Example: Kenya ANC
- If the form name has “L&D” in it - then it's an Labour & Delivery or Maternity form
  - Example: L&D Register
- If the form name has “PN” in it - then it's a Post Natal form
  - Example: PN Mother

11.7.10 Set Form Display Order

All forms created using IQCare Form Builder display in the IQCare browser-based data entry application under the navigation link "Create New Form". The display order under this navigation can be configured using the Order Forms option found in the Manage Forms Screen.

Set Form Display Order

1. Open Manage Forms home details page
2. Click on the Order Forms button



3. Select the technical area. Note that only those forms that are in the published state will display.

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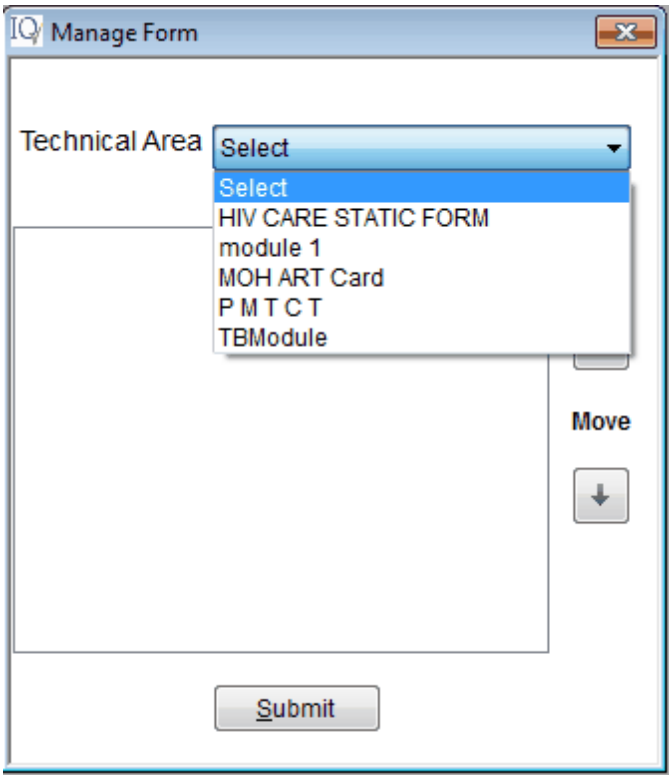
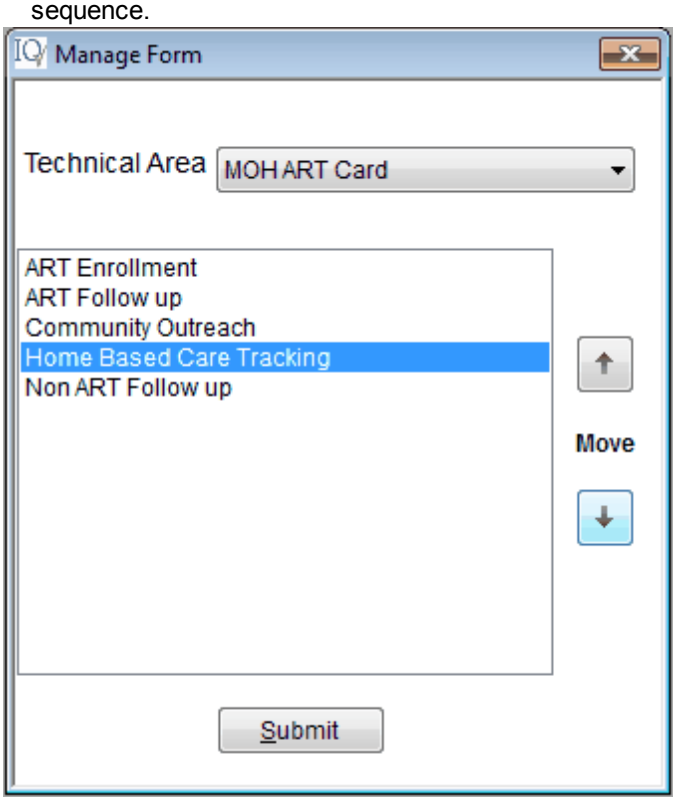


4. Highlight the form name that you want to re-order and use the up and down arrows to re-arrange the sequence.



5. When finished, click submit to save your changes.

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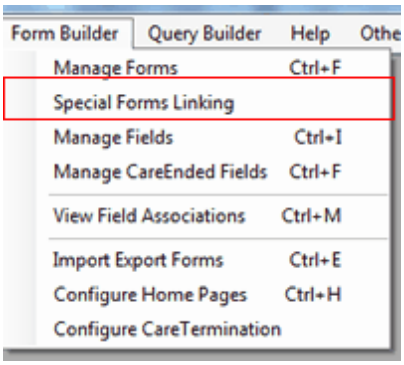
11.7.11 Special Forms Linking

When you create a new technical area, you have the option of adding in these standard static forms:

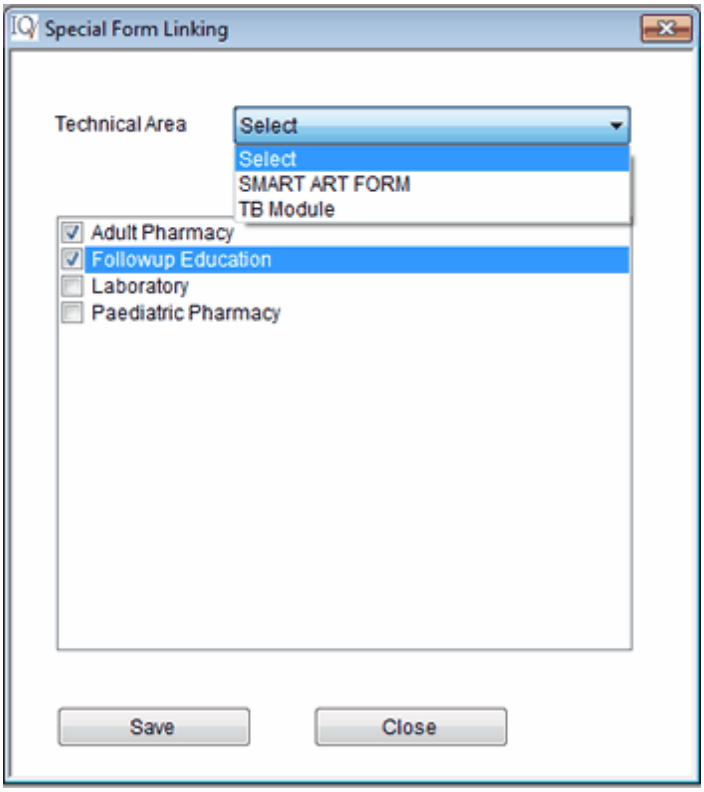
- Adult pharmacy form
- Paediatric pharmacy form
- Laboratory form
- Follow up Education feature/set of form

Add a special form to a technical area

1. In the menu, select Special Forms Linking
2.



3. Select the technical area
4. Select the forms you would like linked by checking the check boxes
5. Click the Save button



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11.8 Manage Care Ended Forms

When a patient or a client in a new technical has completed his/her care, you may need to close their record. IQCare Management provides configuration options so that you can set up different care ended forms for each technical area.

Care ended forms for HIV Care Static Forms and PMTCT technical areas are required. You can change/adjust them as needed however care should be taken so that existing Track 1 reports continue to run correctly. If a newly created technical area does not required a care ended form, IQCare does not required one to be configured.

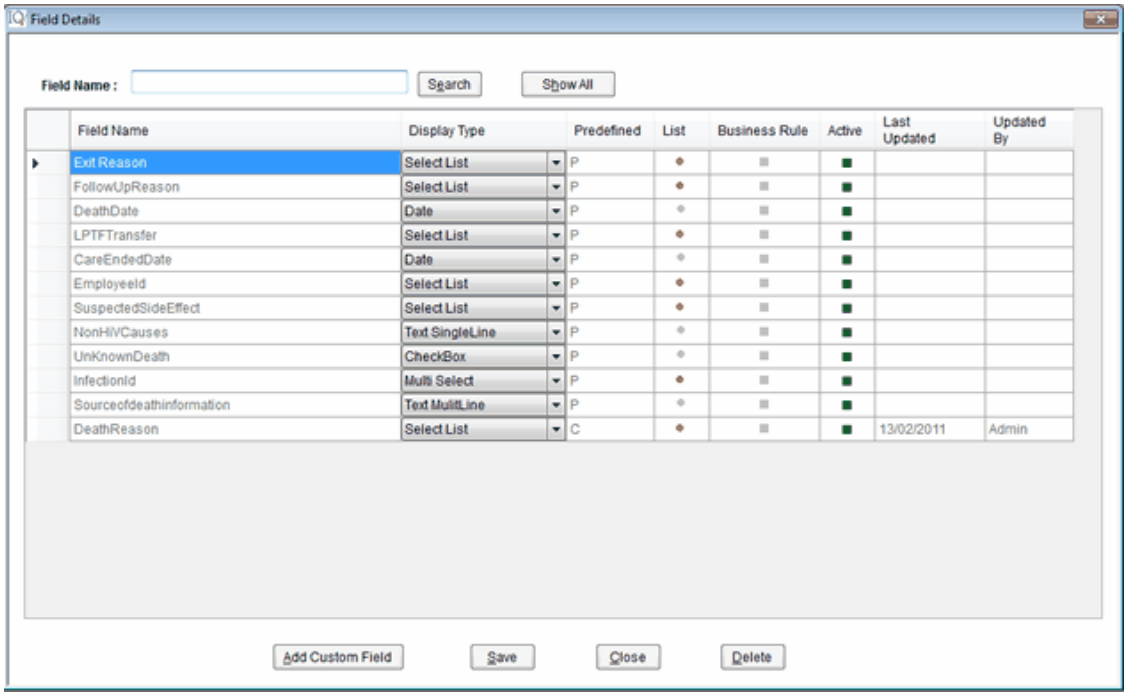
Care ended forms are configured in two steps: first add any new fields required in the Manage Care Ended Fields section; then use these fields in the Configure Care Ended Forms section of the application. These options can be found in the top menu.

11.8.1 Manage Care Ended Fields

For clarity and ease of use, IQCare Management separates the care ended fields and form configuration. The fields are particularly important for the HIV Care and PMTCT technical areas. The Care Ended fields tie directly into the CDC Track 1.0 report (table 6) and therefore, both the HIV Care and PMTCT technical areas must have a Care Ended for configured in order to run that report successfully.

Pre-defined Care Ended fields

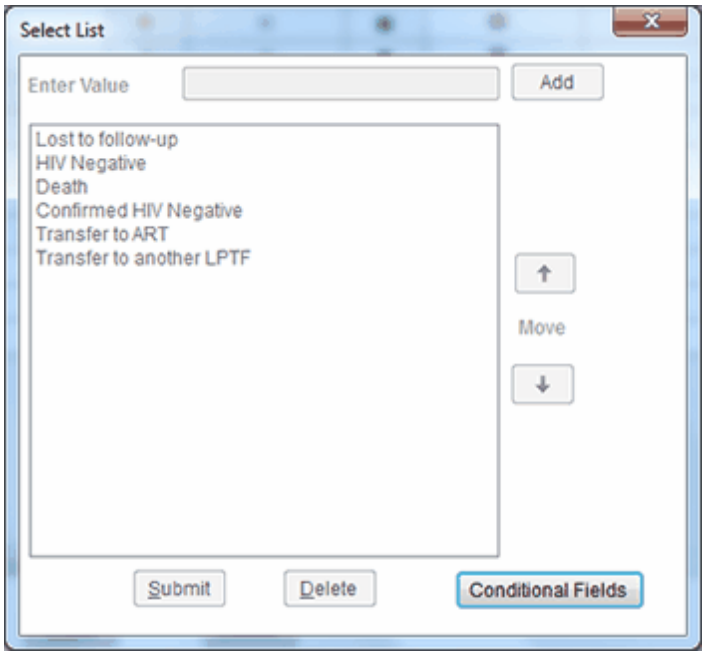
A set of pre-defined fields are available to be used for your Care Ended form. You can also create new fields via Add Custom Field feature. You create custom fields in the same way as you would in Manage Field option in IQCare Management. Create Custom Fields for more information.



The Patient Exit Reason Field

The Patient Exit Reason field is the field that controls the display of the form in IQCare.Each select list entry or exit reason can be associated with one or more fields. When an exit reason is selected, the associated fields display. For example, if the exit reason is Lost to Follow up, the associated field might be the Lost to Follow up reason. The Patient Exit Reason select list is a required field for all care ended forms. There is no limit to the number of other custom fields you can also add to the form.

Default Patient Exit Reason list



Death Reason Field

The Death reason field is the field that controls the display of the death reason fields. If death is an option that is configured as a patient exit reason, the death reason is a field that can be configured so that different and mutually exclusive deaths reason can be selected on the care ended form.

Default Death Reason list

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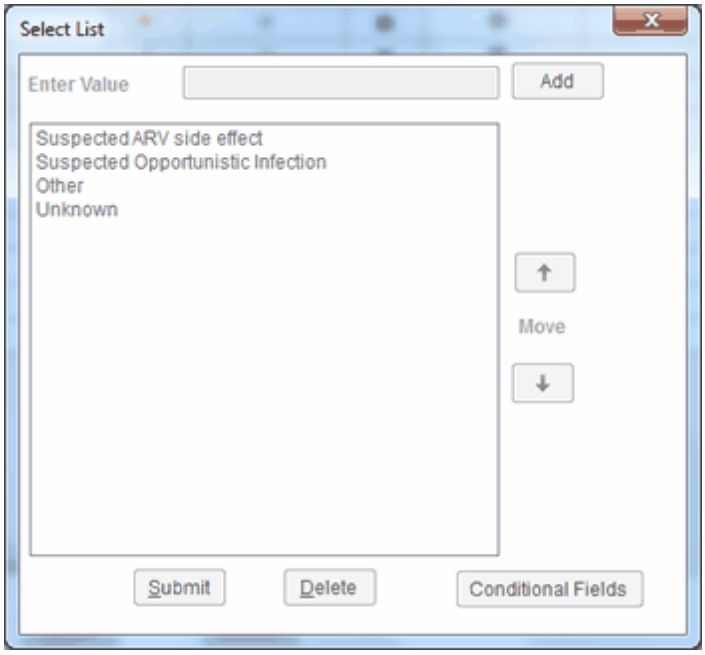

- **Signature and Care Ended Date**

  The **Signature** and **Care Ended Date** fields are always on the form and cannot be removed.

11.8.2 Configure Care Ended Forms

Configuring the Care Ended form is done in three steps

Step 1: Configure the Patient Exit Reason conditional field (required)
Step 2: Configure the Death Reason conditional field (optional)
Step 3: Adding other fields at the "top level" (optional)

- **Step 1: Configure the Patient Exit Reason conditional field (required)**

  1. From the menu, select Configure Care Ended Form. The default list of fields on any form is the ExitReason, CareEndedDate and EmployeeId; These fields cannot be removed from any care ended form.

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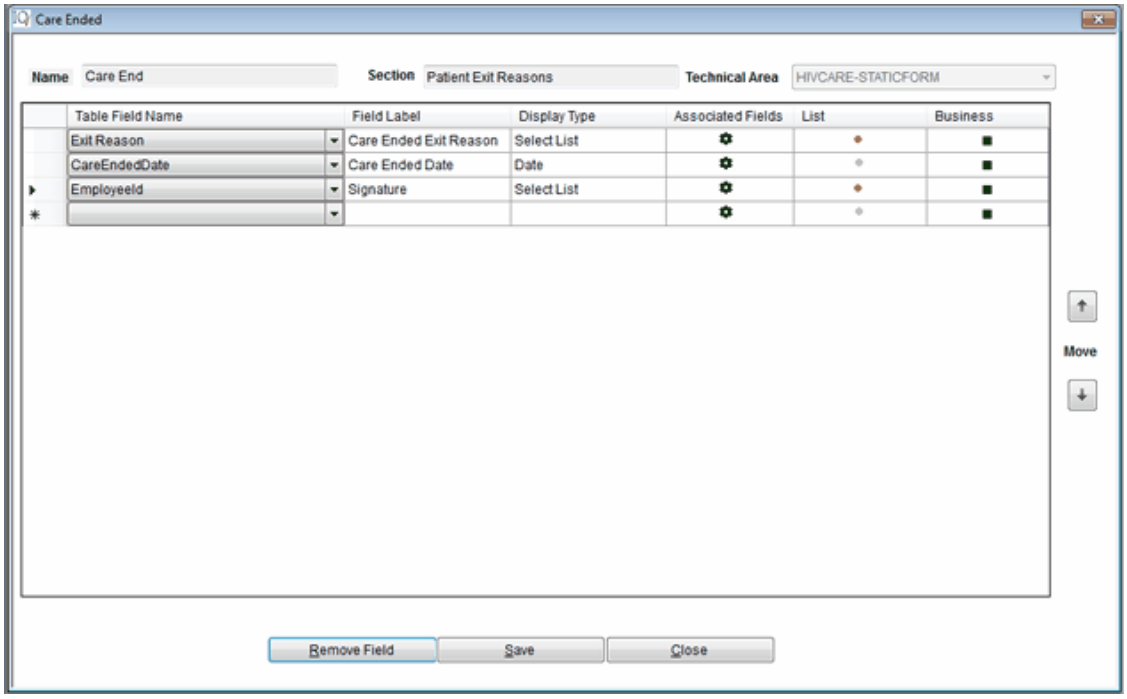
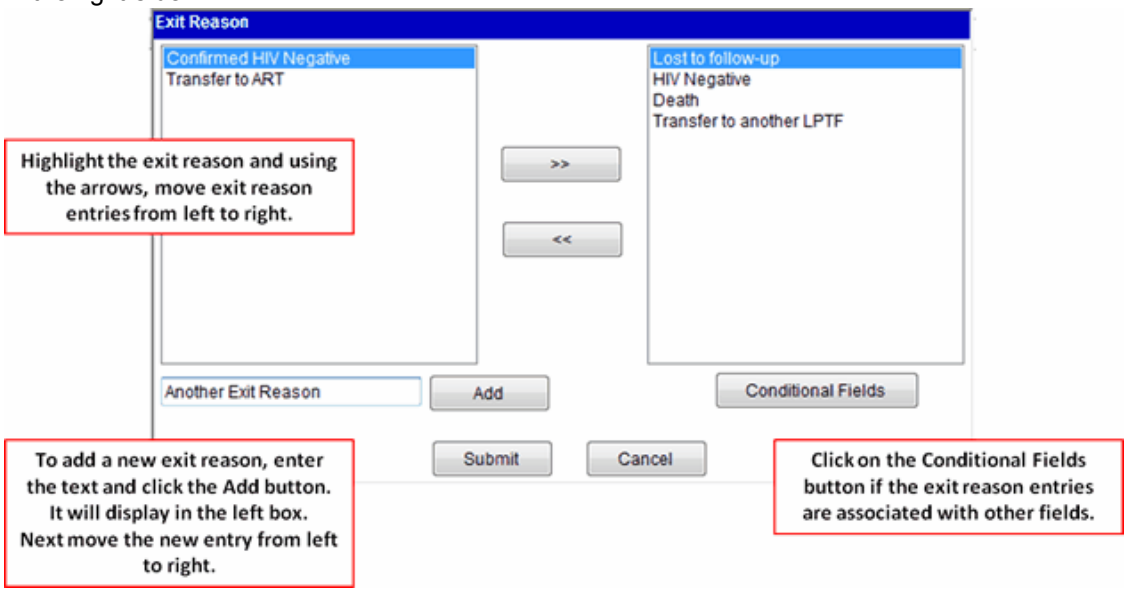


2. Click on the Associated Fields icon in the Exit Reason row to configure the exit reason entries.
3. To add an entry to the exit reason list from the default list, highlight the entry and using the arrow button move the entry to the right hand side. If you have made a mistake, use the arrow button to move the entry back to the left side.
4. If you want to add a new exit reason, enter the reason in the field below the list on the left and click the Add button. This adds the entry to the list. Now move the newly added exit reason to the right side.


Exit Reason
Confirmed HIV Negative
Transfer to ART
Lost to follow-up
HIV Negative
Death
Transfer to another LPTF
Highlight the exit reason and using the arrows, move exit reason entries from left to right.
>>
<<
Another Exit Reason
Add
Conditional Fields
Submit
Cancel
To add a new exit reason, enter the text and click the Add button. It will display in the left box. Next move the new entry from left to right.
Click on the Conditional Fields button if the exit reason entries are associated with other fields.

5. Once you have completed moving the exit reasons to the right side, click the Conditional Fields button. A new window displays.

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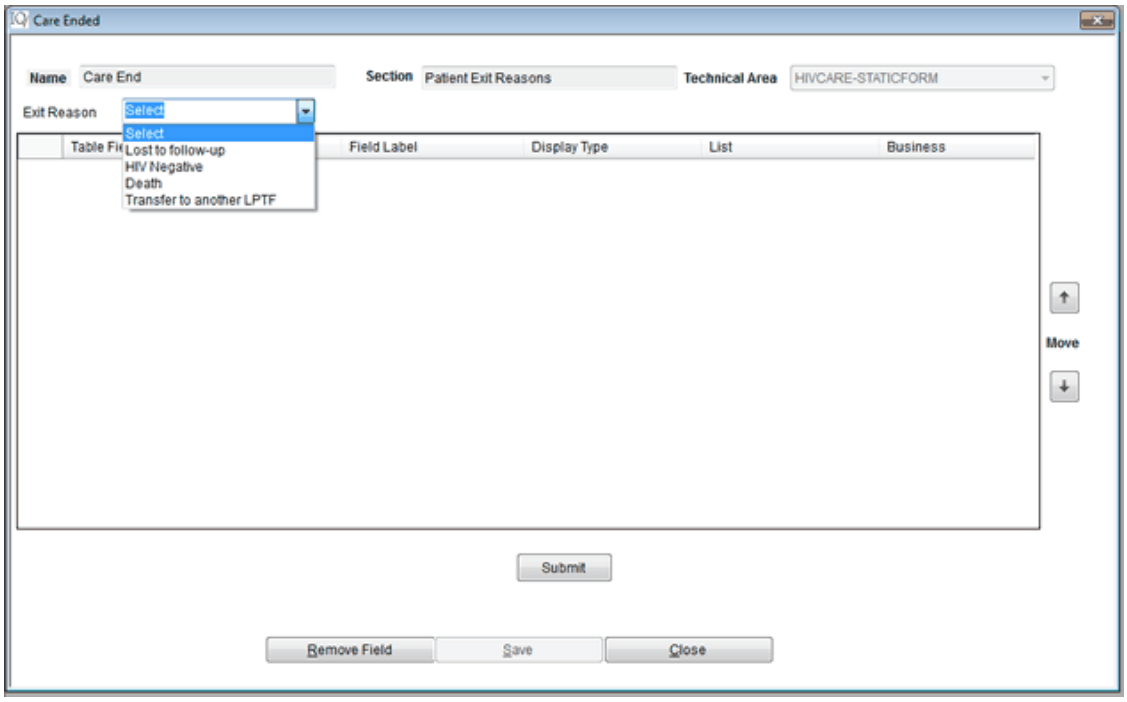
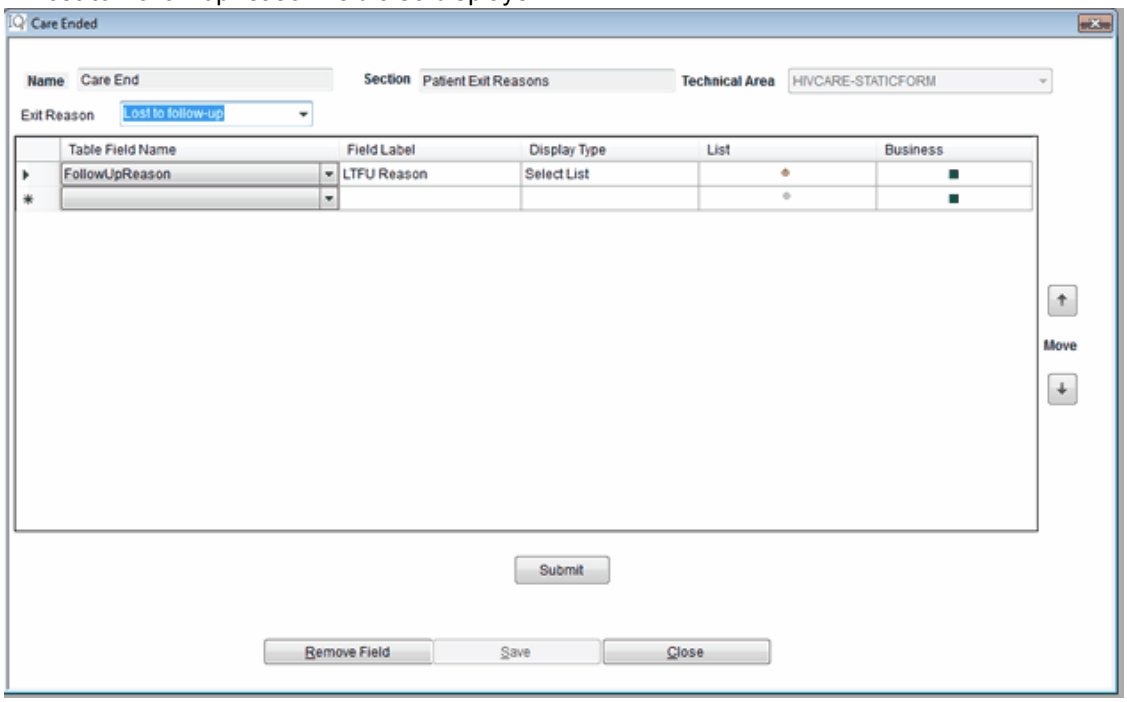


6. Using the Exit Reason select list, select the exit reason you want to add conditional fields for. A grid displays allowing you to select the conditional fields. In this example, the exit reason Lost to Follow up" is selected; the associate field "FollowUpReason" which is a select list type field is configured. In IQCare, in the Care Ended form, when Lost to Follow up is select, the Lost to Follow up reason field also displays.



7. Repeat adding fields to the selected Patient Exit Reason until you are done with this exit

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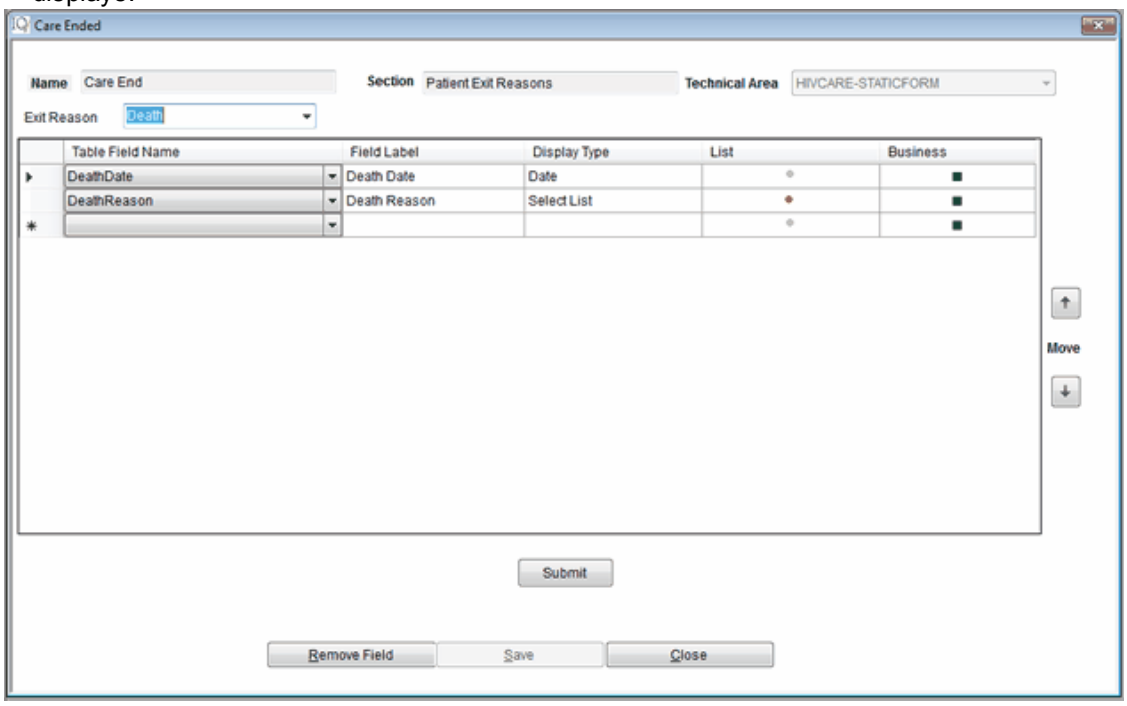
reason.
8. Using the Exit Reason select list, select another exit reason.
9. Add conditional fields.
10. Repeat this process until you have configured all of the exit reason entries. Note that an exit reason does not have to have any associated fields.
11. Click Submit to save the Exit Reason configuration and return to the top level configuration page.
12. Be sure to click the Save button in the Care Ended Form to save all your work and commit the configuration to the IQCare database.

Step 2: Configure the Death Reason conditional field (optional)

One of the Patient Exit Reason entry options is Death Reason. This is a special field and it too can be configured with conditional fields. In the same way as the Patient Exit Reason field, you configure the Death Reason field. In IQCare if Death is selected as a Patient Exit Reason, the Death Reason select list displays. Depending on the death reason, other fields will also display. For example if the death reason is Suspected Side Effects, a select list of side affects displays. The Death Reason select list provides two levels of drill down - one from the Patient Exit Reason -> Death Reason -> Various data collected on the reason for death.

1. Select Death from the Patient Exit Reason select list; Note that two fields will always default and cannot be removed; they are the Death Date and the Death Reason.
2. Click on the orange dot in the List column for the Death Reason field; the list options dialog displays.



3. Using arrows, move the defaults death reasons you want to display in the IQCare form from left to right box.
4. Add any new death reasons fields using the Add field and button and move them from the left to the right box.
5. Click on the Conditional Fields button; a new dialog displays

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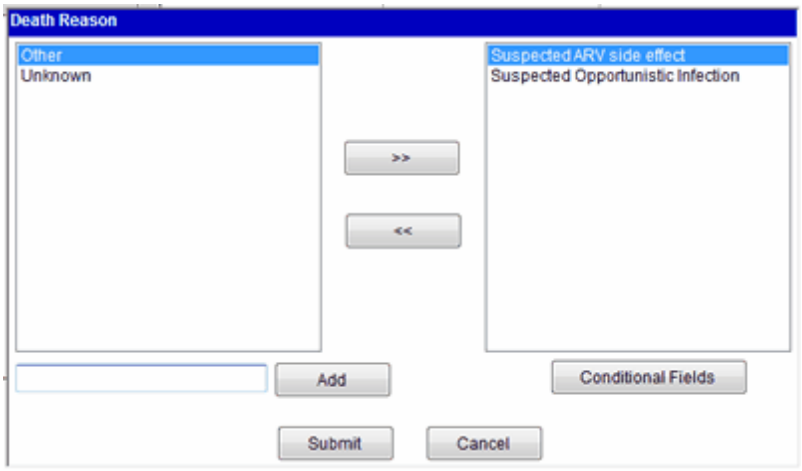
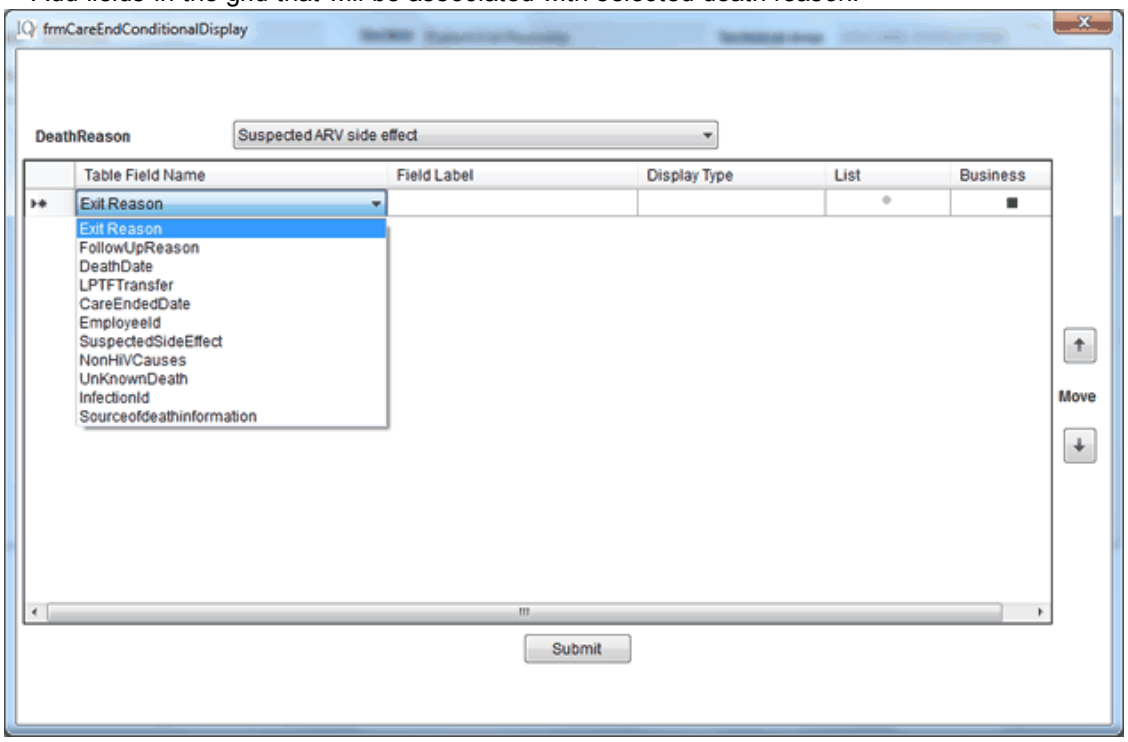


6. Using the select list select the death reason field. In this example the Suspected Side Effects reason is selected.
7. Add fields in the grid that will be associated with selected death reason.



8. Repeat this process for all of the death reason entries. A death reason does not have to have any associated fields. In this case the grid would be blank.
9. Click Submit to submit your work and return to the Patient Exit Reason screen. Be sure to click the Save button in the Care Ended Form to save all your work and commit the configuration to the IQCare database.

Step 3: Adding other fields at the "top level" (optional)

You can add any number of additional fields to the care ended form. These fields stand on their own at the top level of the form. You will need to create these fields in Manage Care Ended Fields.

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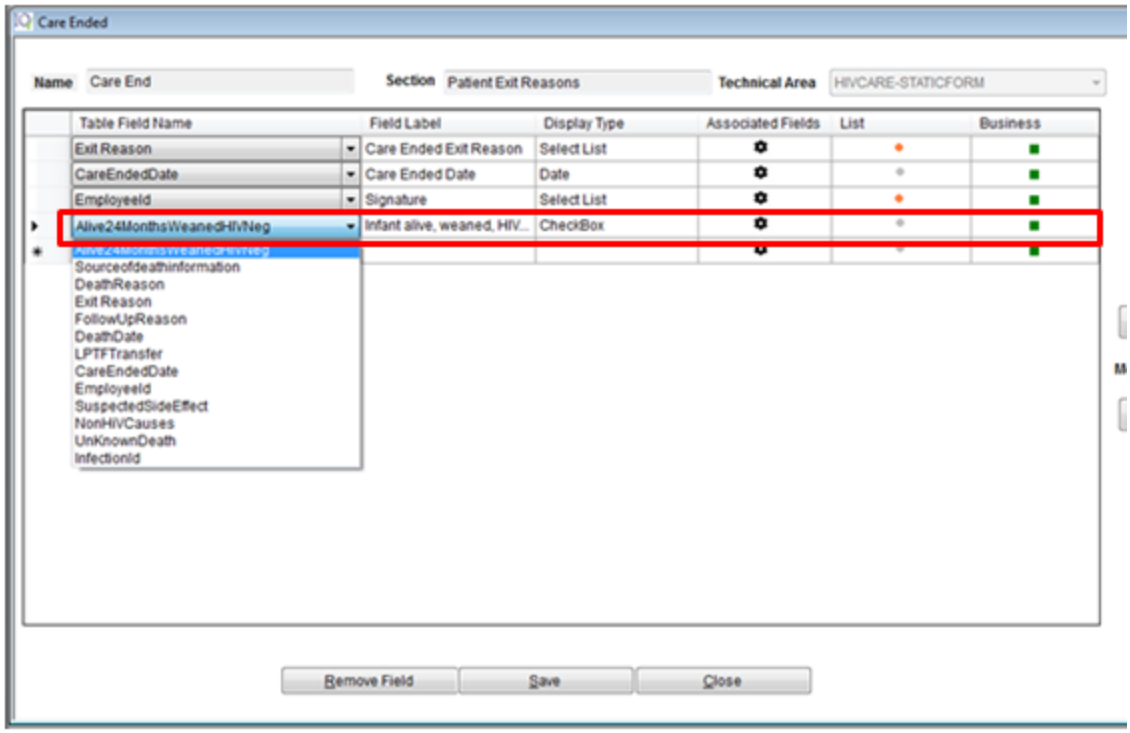
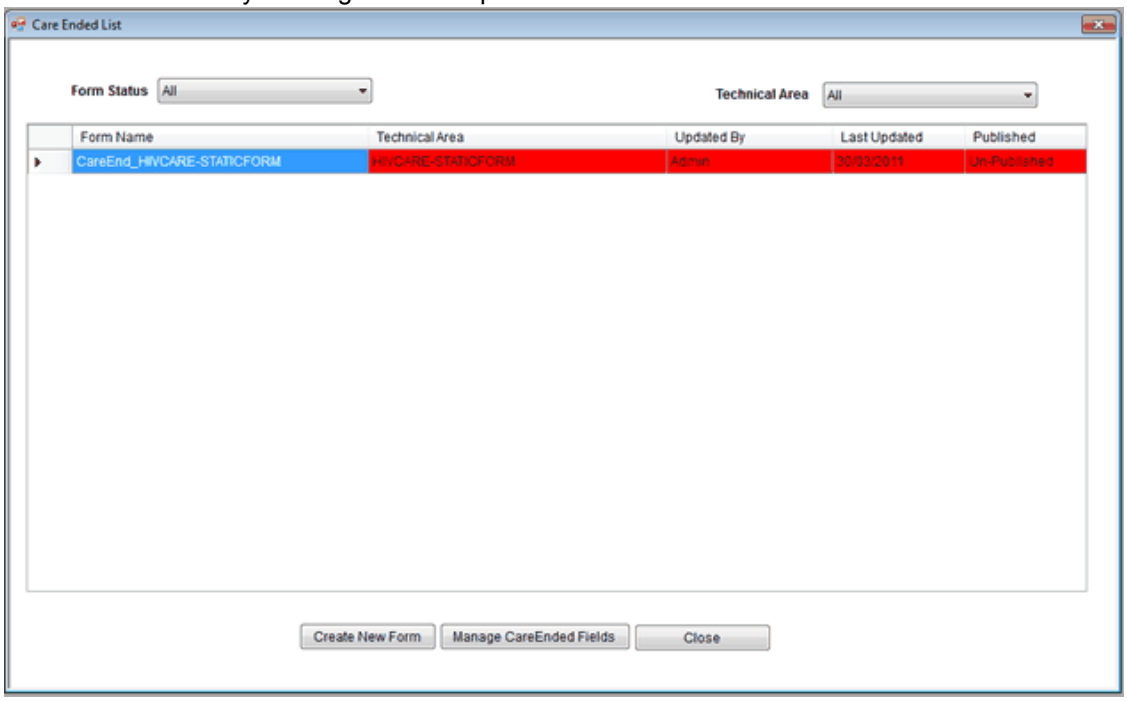
1. In the main Configure Care Ended Forms dialog, select the fields you would like to add to the form.



2. Click the Save button to commit the entire configuration to the IQCare database.
3. Publish the form by clicking on the Un-published cell for this form



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11.9 Manage Registration Form

Before you can enter patient data, you must first register the patient into IQCare. To register collect contact information about the patient and his/her treatment supporter, you may want to add sections to the IQCare Universal Registration form.

11.9.1 Manage Registration Fields

There is a minimum set of fields that must be captured in order to register the patient into the system. These fields display in the first section of the registration form and they cannot be removed or configured. You add sections to the registration form by using predefined fields and custom fields.

Fields found in the first section of the registration form

These field are found in the first section of the registration. They cannot be changed in any way.

Display Label	Display Type	Table	Field	Required
Patient Name First	Text box	mst_Patient	FirstName	Yes
Patient Name Middle	Text box	mst_Patient	MiddelName	
Patient Name Last	Text box	mst_Patient	LastName	Yes
Sex	Select list	mst_Patient	Sex	Yes
Date of Birth	Date	mst_Patient	DOB	Yes
Exact, Estimated	Radio	mst_Patient	DobPrecision	
Age	Calculated			
Marital Status	Select list	mst_Patient	MaritalStatus	
Registration Date		mst_Patient	RegistrationDate	Yes

Here is how these fields display in IQCare

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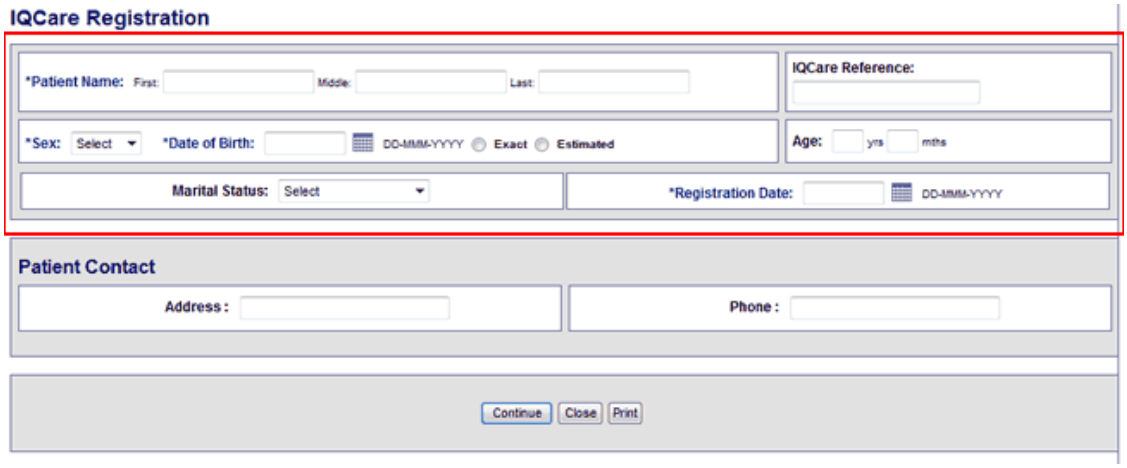
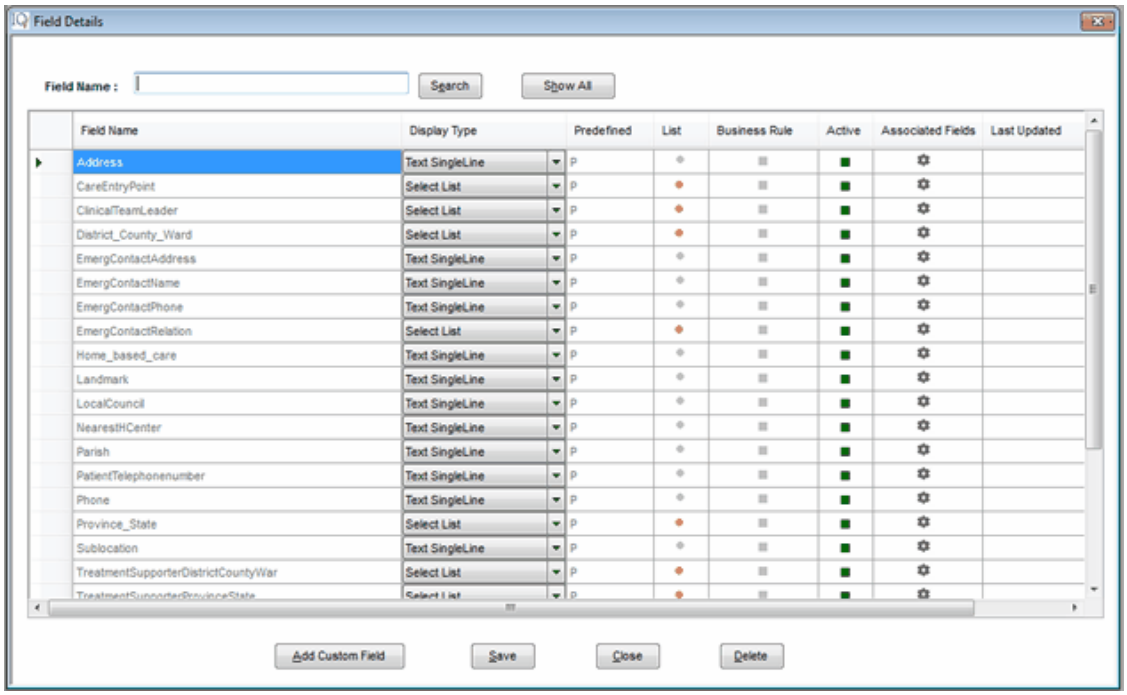


Pre-defined Registration fields

A set of pre-defined fields are available to be used for your Registration form. You can also create new fields via Add Custom Field feature. You create custom fields in the same way as you would in Manage Field option in IQCare Management. Create Custom Fields for more information.



11.9.2 Configure Registration Form

The Registration form is configured in the same way as you would configure a form builder form. Note that will only ever be one instance of this form. Unlike the Care Ended form where you can configure an instance of the form per technical area, this form is used for the entire application and there is only one version of the form. The Create New Form button will be disabled after you have created the registration form.

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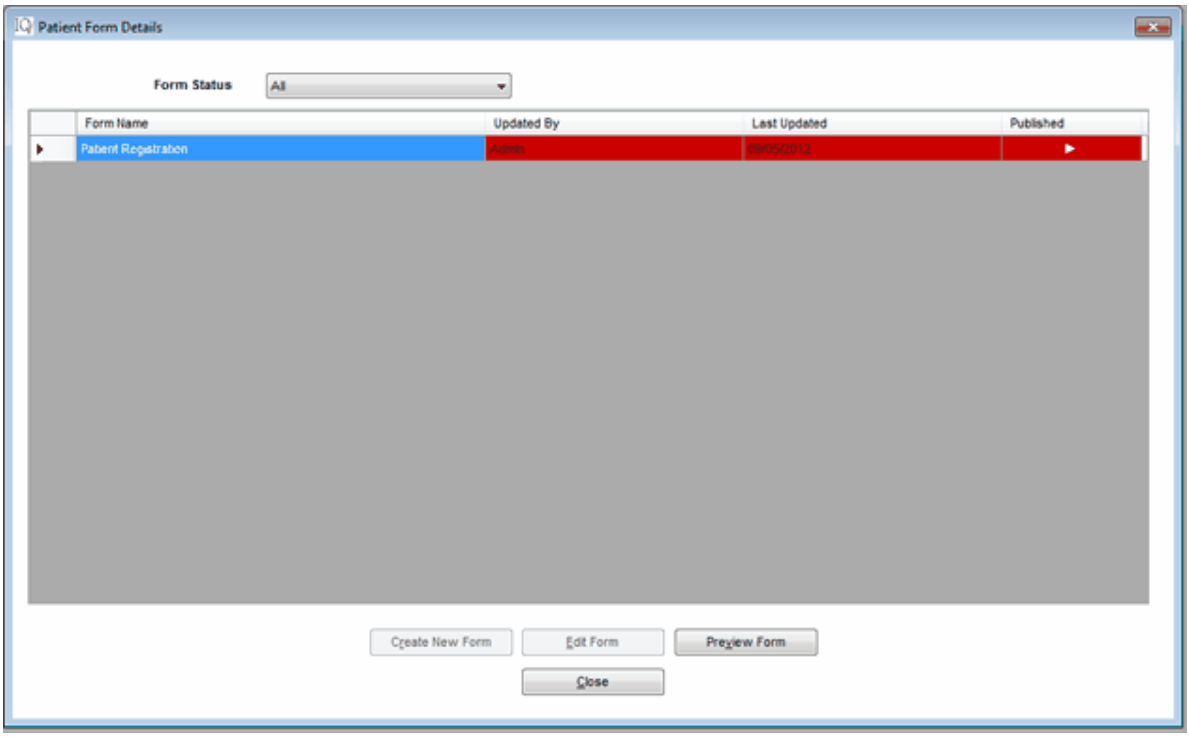
1. Make sure the registration form is un-published; double click on the form row to open it for editing



2. Update the form name as needed
3. Add a section and then add fields. Adjust the order of the fields by using the up and down move arrows.
4. Add new sections and fields as needed. Order the sections by using the Manage Section button.
5. When complete, click Save

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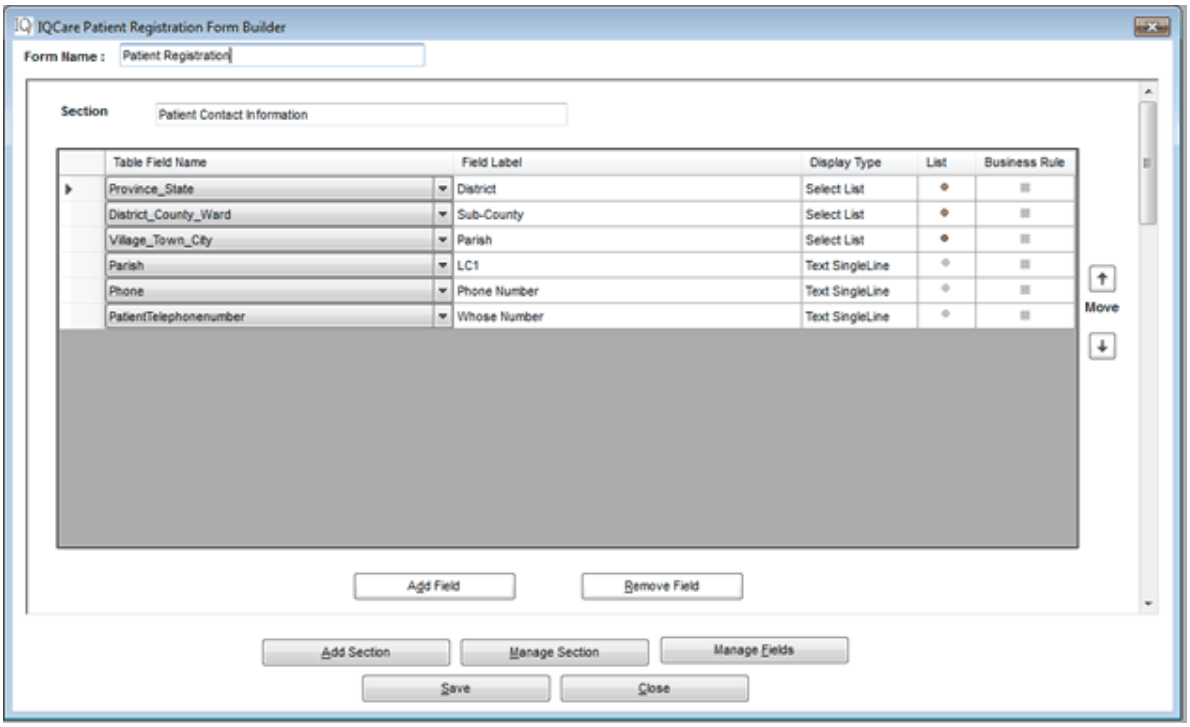

11.10 Configure Home Pages

When you create new technical area, it's likely that you also want to display information about the client/patient population (facility home page) and specific patient information (patient home page). For HIV Care and PMTCT, the facility and patient home pages are pre-defined. For new technical areas, you can define your own queries.

Facts about home pages:

- The home page queries can be any query that will run on the database. You should test your queries using the QueryBuilder feature provided, to verify the output is what you want.
- There is no restriction to the number of queries you can add to your home pages
- The facility home page will default the technical area title; the count results display under the title
- The patient home page counts will display in its own tab with the technical area name

Preparing Home Page Queries

When you configure the home pages, you will be specifying the indicator label text and cutting and pasting the query into a query window. The best approach is to have your queries ready before you configure the home page you are working on. You can create your queries using the Query Builder which shows you all of the IQCare tables and fields and provides an easy-to-use interface for you to create and test your queries.

IQCare Home Page Query Display with One, Two or Three Output Results

IQCare provides the formatting ability to for one, two and three output results. Three return results is the maximum you can configure per line of the home page report. The display is directly dependent on the query you enter for the indicator.

- Queries that have one return result will display as a single number
- Queries that have two or three return results will display in a table format.

In this Facility Home Page example, two indicators are configured for the technical area MOH

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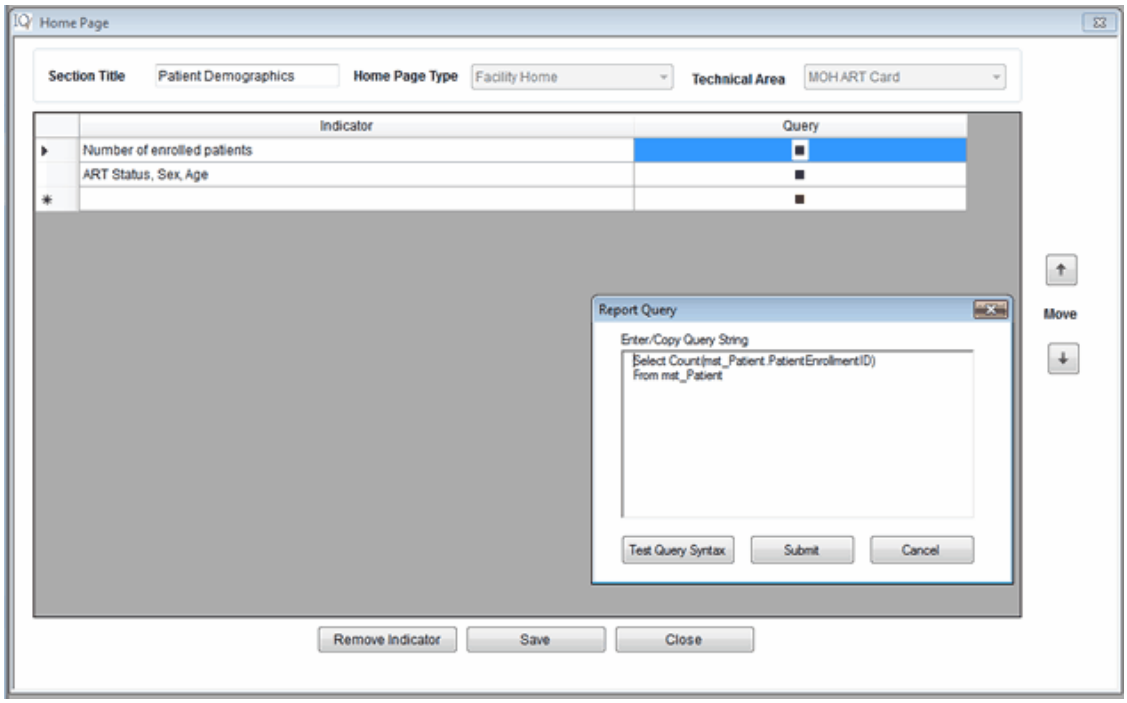
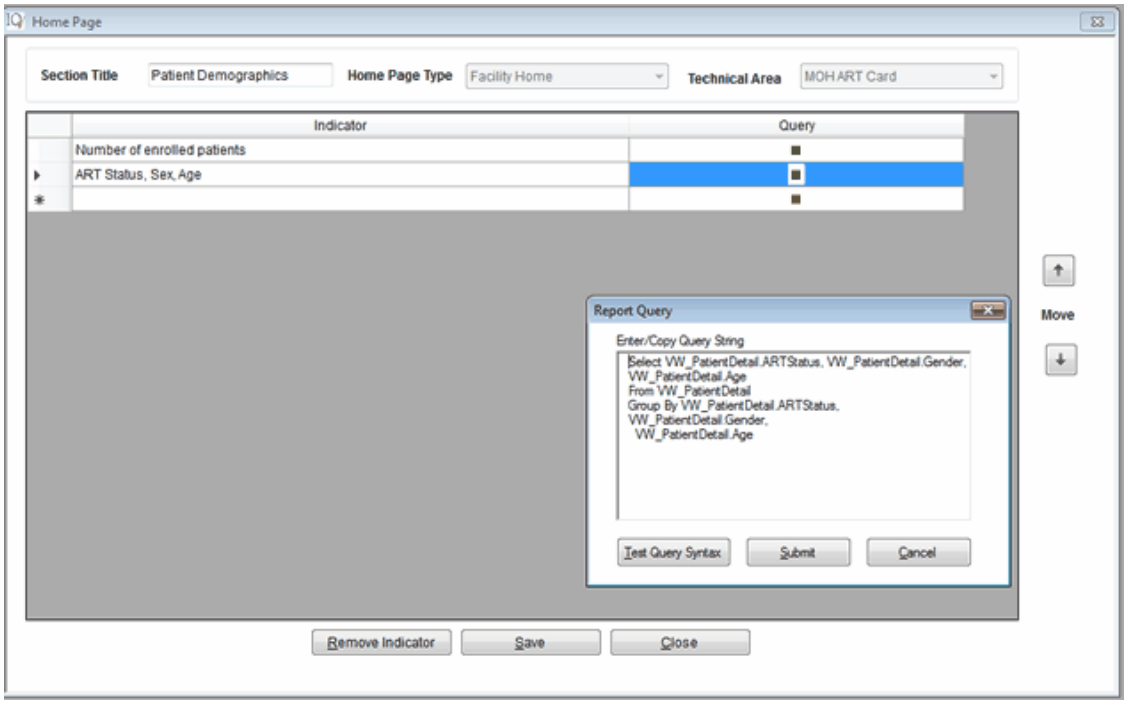
ART Card. The first indicator query calculates the number of enrolled patients in the system and returns one result.



The second indicator query pulls data on ART Status, Sex and Age and returns 3 results in a table.



Here is what the Facility Home page display looks like for the above set up.

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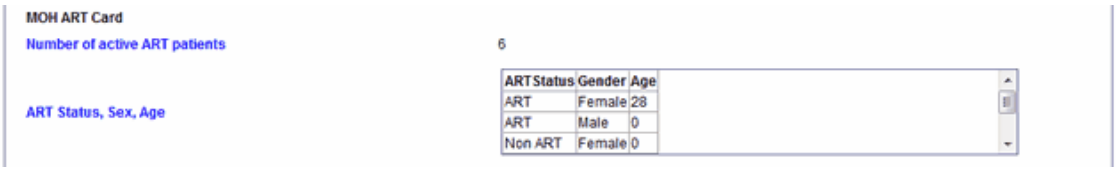
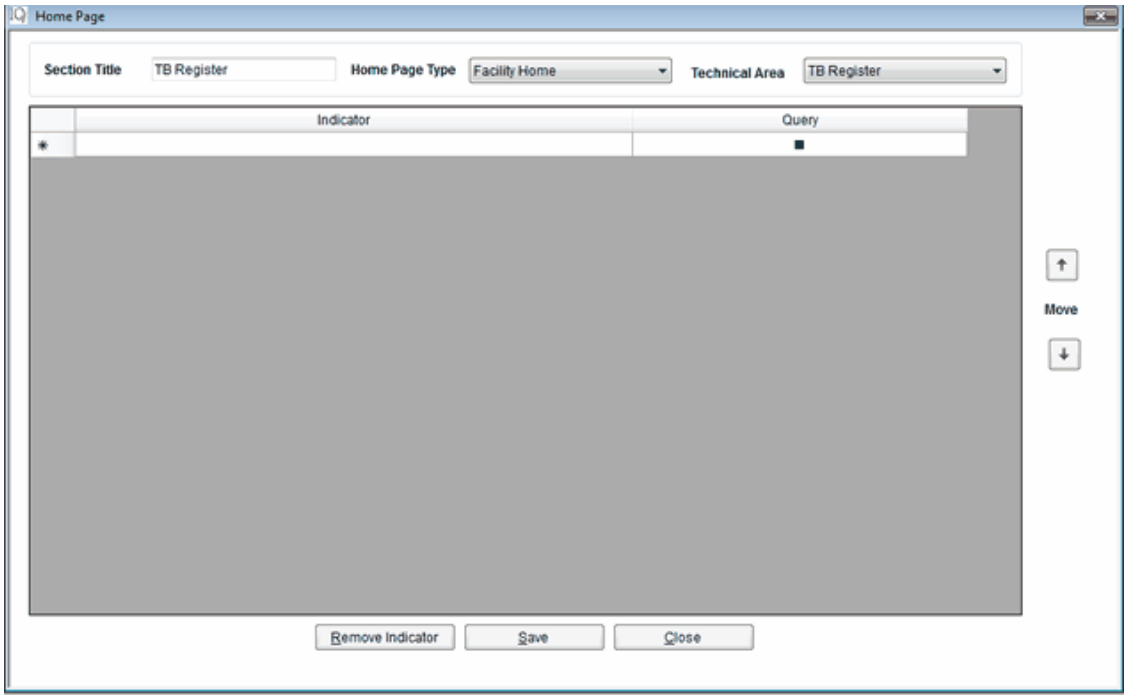


Configure Facility and Patient Home Pages

1. From the menu, select Configure Home Pages
2. Enter the Section title, home page type and the technical area



3. Enter the text that will display on the home page; note that once text is in the field, the Query icon turns red. This means that a query has not yet been specified for this report indicator.
4. Click on the Query icon to open the query window
5. Cut and paste the query into the window
6. Check the syntax by clicking the Test Query Syntax button.
7. Click submit.

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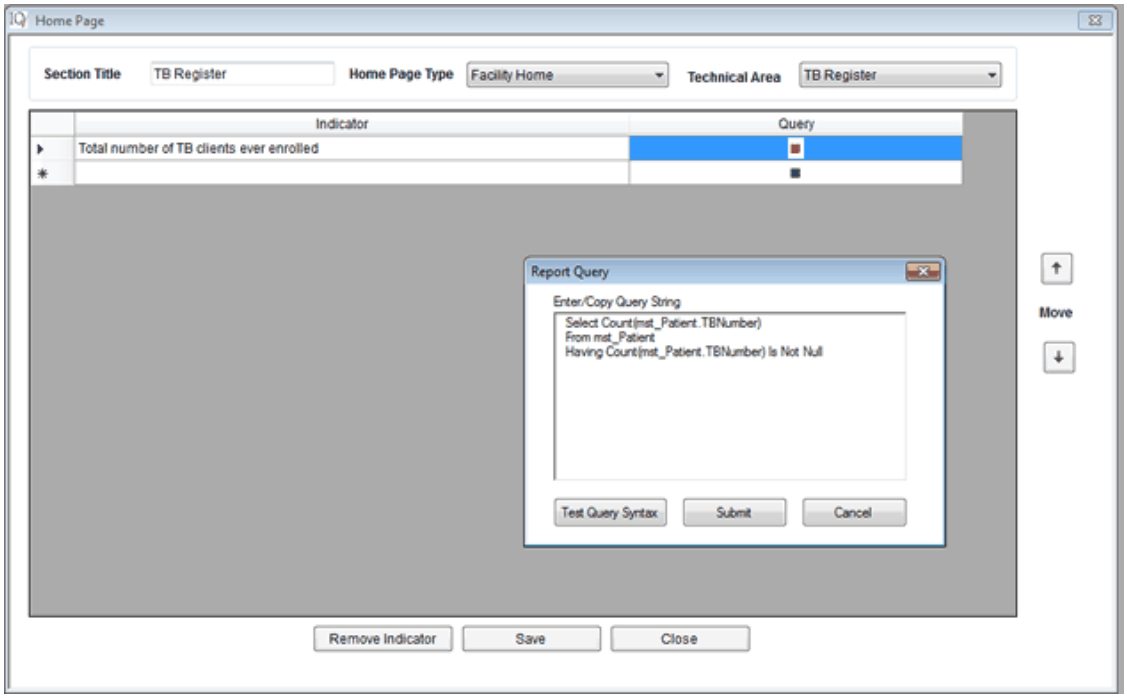
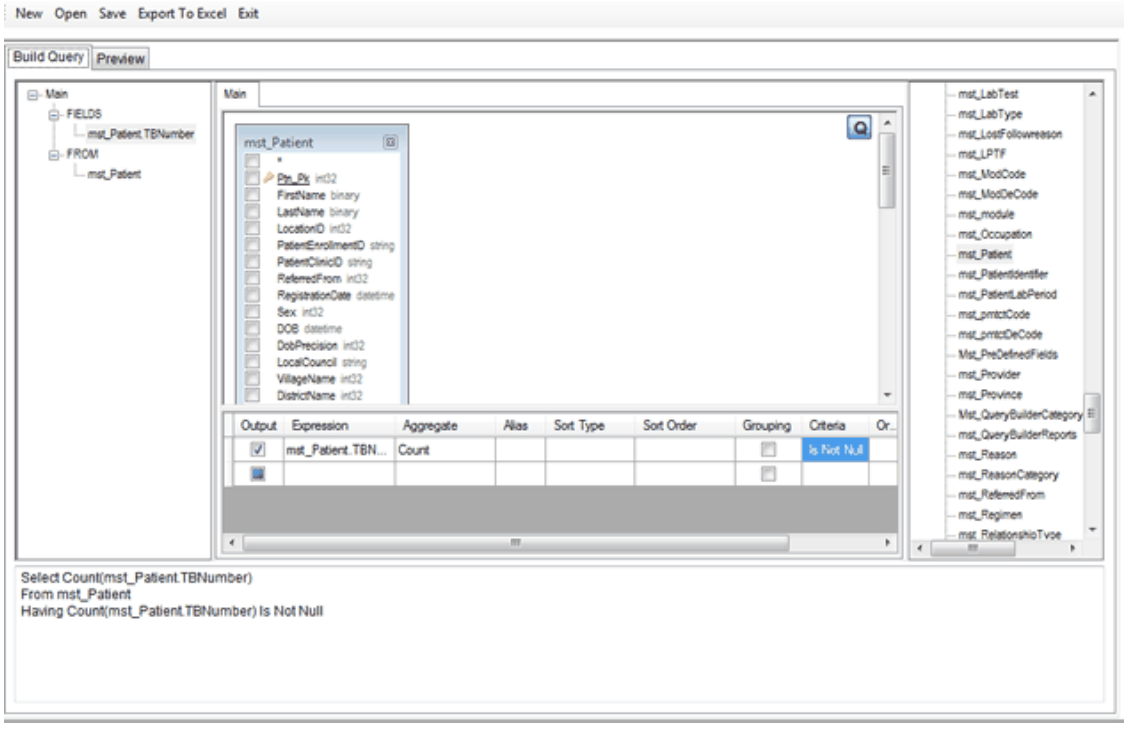


8. Upon submitting, the icon turns to green in the home page window for the home page you are working on.

Here an example of creating the query using the query builder for the indicator in this home page.



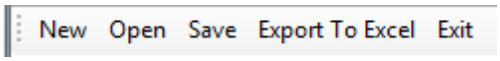
11.10.1 Query Builder Navigation

The Active Query Builder is a software package that has been integrated into the IQCare Management application. This tools accesses the tables and fields from the IQCare database. Using the query builder you can create, run and save custom queries. This tool will help you create the queries needed for the facility and patient home pages

The query builder has 4 key functions.

- Design and preview queries
- Save and retrieve queries

Query Builder Page Controls



The query builder has a number of pages controls.

New	Opens a new query screen
Open	Opens an existing query
Save	Saves a query
Export to Excel	Exports query results to Excel
Exit	Closes the Query Builder window

Query Design Sections

The design page is composed of 5 different sections as described and illustrated below:

- **Section 1**: Displays the columns and tables/views the active query has
- **Section 2**: Shows the tables/views that are being used to build the active query
- **Section 3**: Shows all tables/views available for building queries in IQTools
- **Section 4**: Shows the columns that will be available on the final output; you may sort, group, set selection criteria from this section
- **Section 5**: Sets/gets the SQL syntax for the active query

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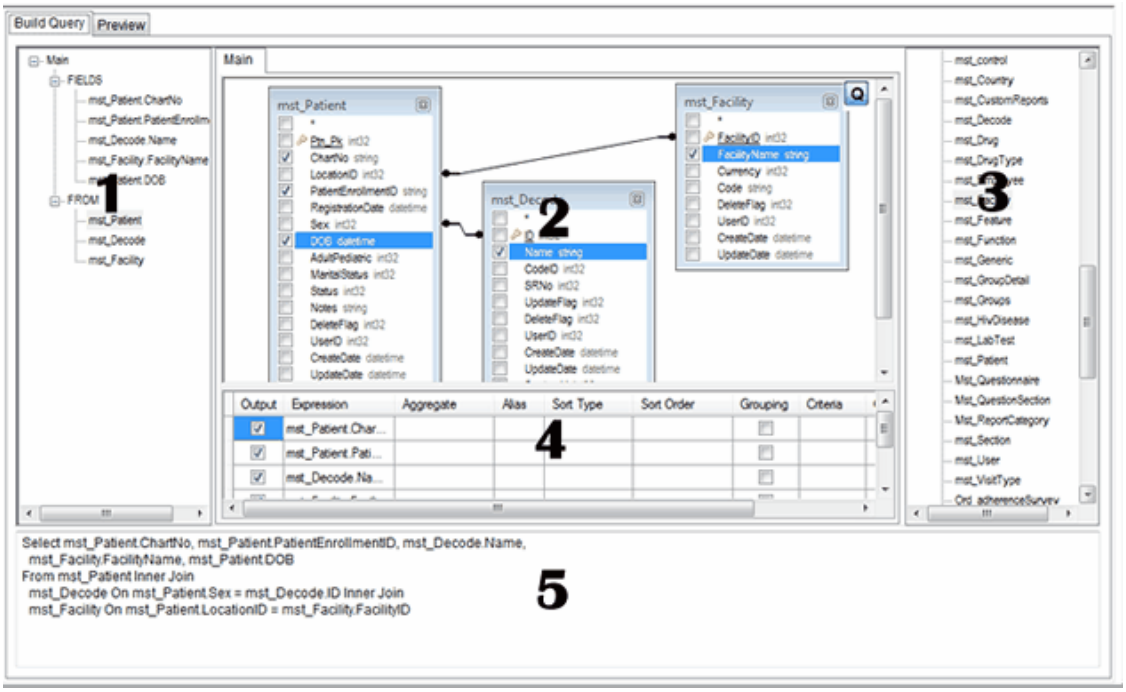
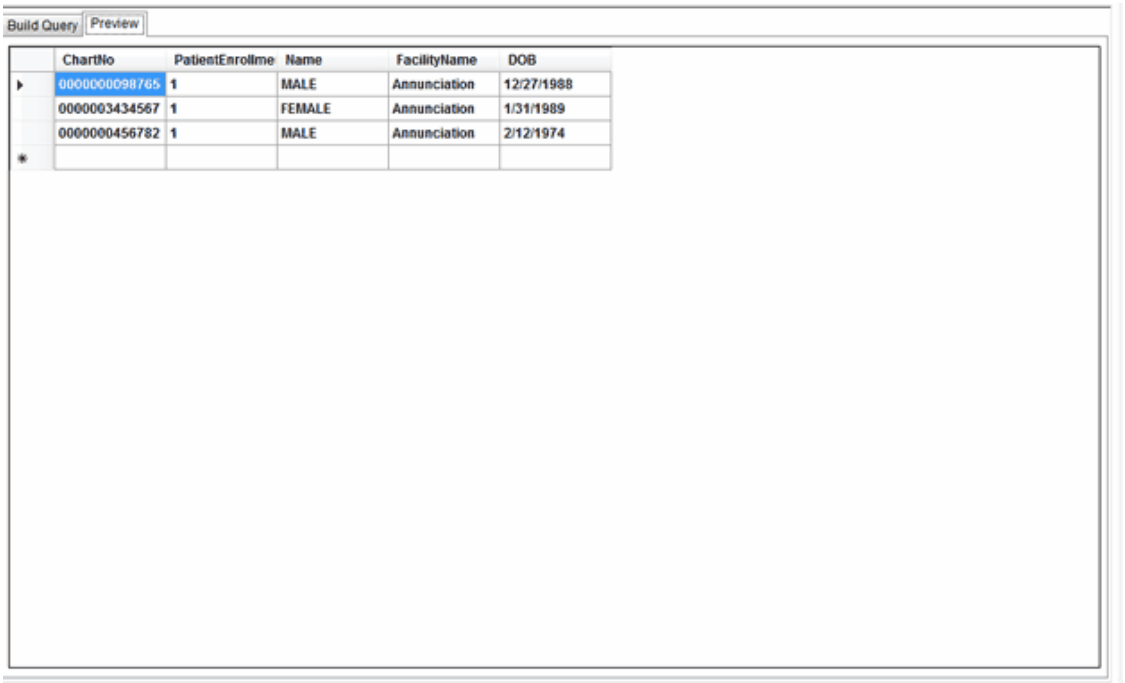


The Preview Tab shows the results of the query you built in the Query Builder tab.



11.10.2 Design and Preview Queries

The following example will take you through the steps of creating your first query.

For more details please see the Active Query Builder User Guide active query builder site.

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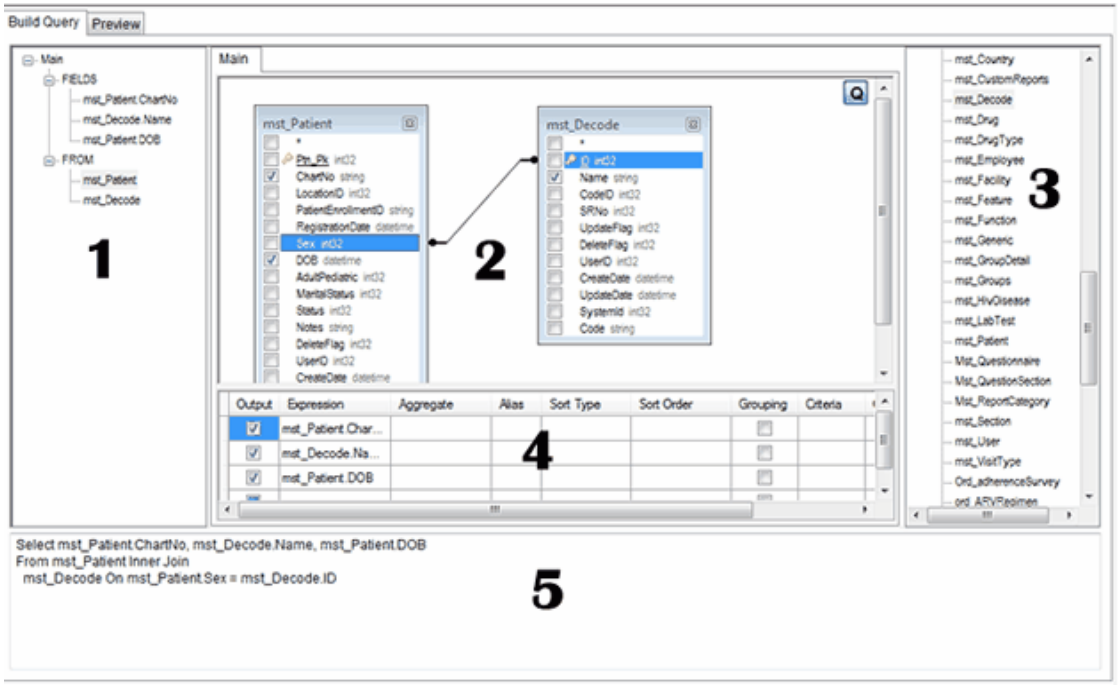
Query design example

Task: Create a query that displays the following patient demographic information

- Patient chart number
- Date of birth
- Sex

Steps to follow in accomplishing the task:

1. From section 3, see illustration below, drag in the mst_patient, the patient master table into section 2.
2. Click on the check boxes to display ChartNo, DOB and Sex
3. Notice the changes in sections 1, 4 and 5.
4. Click on the Preview tab to see your results. Note that the Sex column displays "1's and 2's". "1" is for male and "2" is for female. The translation to text for these variables is found in the mst_decode table, the table where many of the text names are stored. (The reason that the text is not stored throughout the tables is because as the database gets large, queries run faster when mostly numbers are used.)
5. From section 3, drag in the mst_decode table into section 2.
6. Highlight the Sex field in the mst_patient table, left mouse click and drag to point to the ID field in the mst_decode table. A line will be automatically drawn to show that the tables are joined.
7. Check the Name field to display the name associated with the ID
8. Click on the Preview tab to see the results



Result as seen in the Preview page

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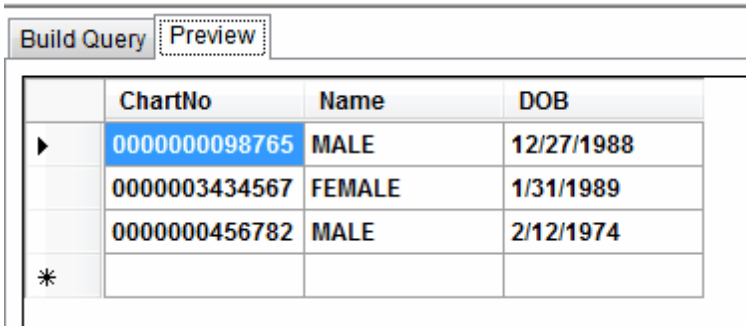
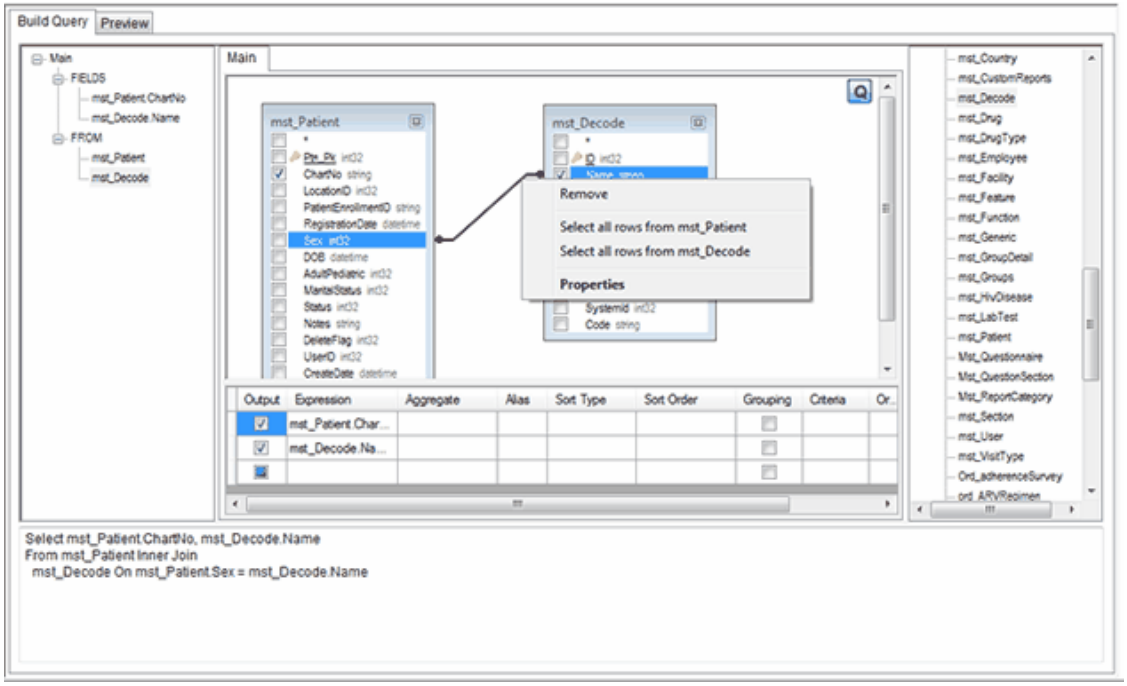


Removing a link between tables

If you find that the link between tables is not correct by looking at the results, or you get a database error, you will need to remove and re-join the tables. To remove a link, right click on the line between the tables and select Remove.



11.10.3 Save and Retrieve Queries

Once you are satisfied with the results of your query, you can save them and retrieve them again in the future. As well you can run them in IQCare under the Reports/Query Builder Reports.

To save a query

1. Click the Save icon in the upper left corner of the Query Builder screen
2. Select a report category

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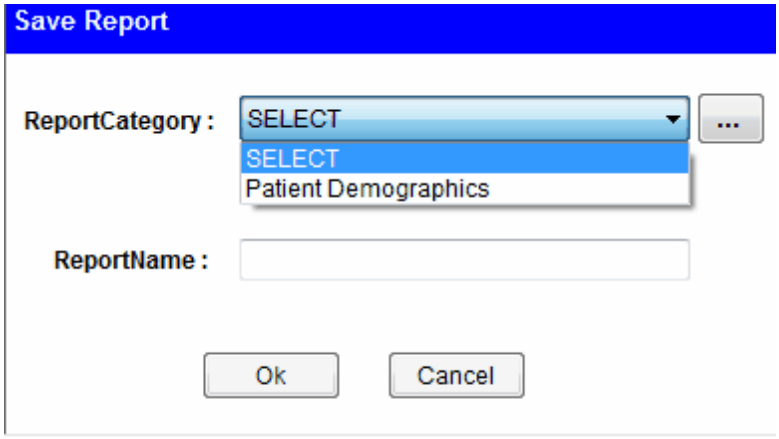
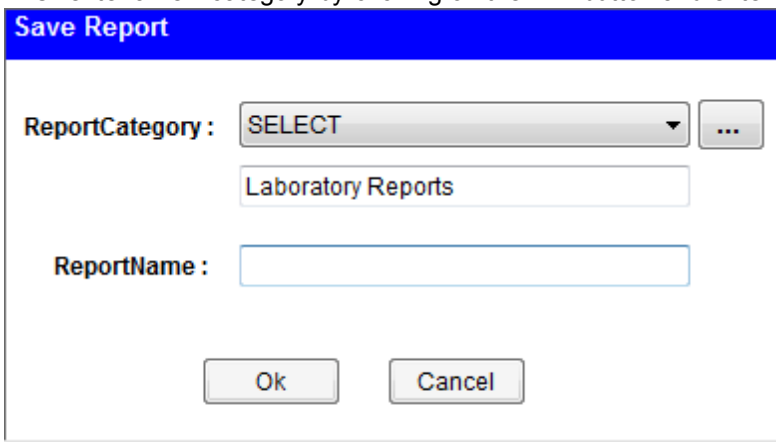
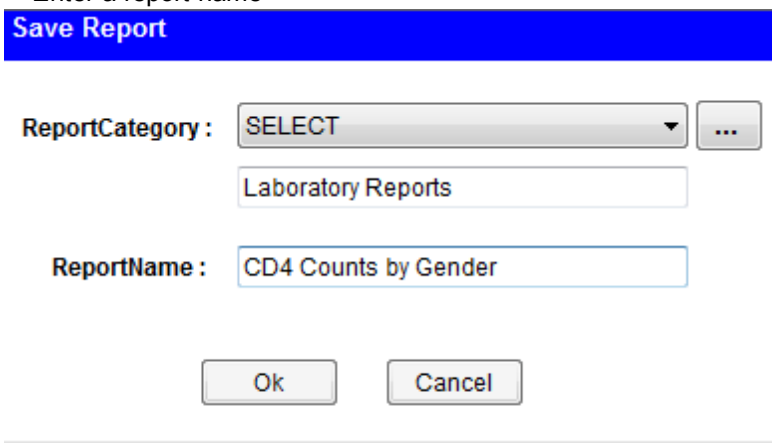


3. Or enter a new category by clicking on the "..." button and entering a name not in the list.



4. Enter a report name



5. Click OK to save

To retrieve an existing report

1. Click the Open Report icon in the upper left corner of the Query Builder screen
2. Select the report category
3. Select the report name
4. Click OK and the report set up will display in the main Query Builder screen

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Part

12 Forms Data Dicationaries

IQCare provides features for both static and dynamic forms.

Static Forms
Static forms that can be a added to any technical area (pharmacy, lab, follow up education)
AIDSRelief form set and the Uganda Blue Card form set

Dynamic Forms
Common registration forms - universal registration form and care ended form
Form builder forms will have their own data dictionary which will be made up of a combination of predefined fields and custom fields.

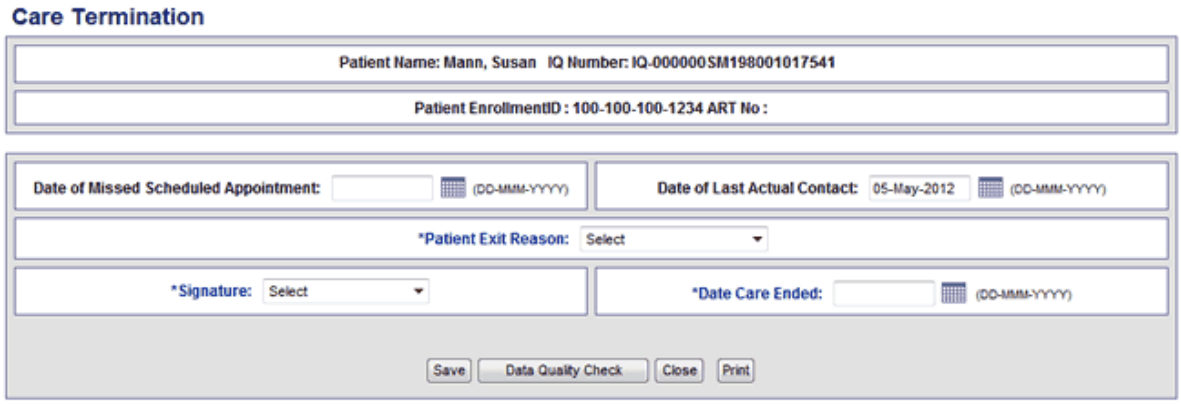
12.1 Common Dynamic Forms Data Dictionary

The Universal Registration and the Care Ended forms can be configured to the needs of the site. There are pre-defined fields available and also you can create your own custom fields. The data dictionary for the pre-defined fields are documented here.

Data dictionary for pre-defined fields:
- Universal Registration Form
- Care Ended Form

12.1.1 Care Ended Form

The Care Ended form can be created for each technical area. And as such the data dictionary for each version of the form may be different. There are a set of pre-defined fields available for the Care Ended form and there are a set of required fields that cannot be removed from the form.



Field Label	Database Table	Field Name	Business Rule	Required for Saving	Minimum Reporting	Minimum Clinical
	mst_Patient	FirstName	Auto filled	Yes	Yes	Yes
	mst_Patient	LastName	Auto filled	Yes	Yes	Yes

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	mst_Patient	PatientEnrollmentID	Auto filled	Yes	Yes	
	mst_Patient	PatientClinicID	Auto filled	Yes		Yes
Date of Missed Scheduled Appointment	dtl_PatientCareEnded	MissedAppDate	Auto filled: Last appointment where AppStatus=Missed			Yes
Date of Last Actual Contact	dtl_PatientTrackingCare	DateLastContact	Auto filled but editable Check the latest date from the latest Enrollment/IE/FU visit date; Adult/Pediatric pharmacy DispensedByDate; Laboratory RepotedByDate; Home Visit last date for which the patient data was captured		Yes	Yes
Patient Exit Reason	dtl_PatientCareEnded	PatientExitReason	Options: Configurable - Default available options are: Death, Lost to Follow up, Transferred out, HIV Negative, Confirmed HIV Negative, Transfer to ART. Custom reasons can be added.	Yes	Yes	Yes
Signature	dtl_PatientCareEnded	EmployeeID		Yes		
Date Care Ended	dtl_PatientCareEnded	CareEndedSignatureDate	Care ended date must be greater than last contact date	Yes	Yes	Yes
		Print	This button is used to take hard copy of the form. This is basically feature of paperless, but is implemented for non paperless too			

Available Pre-defined Fields

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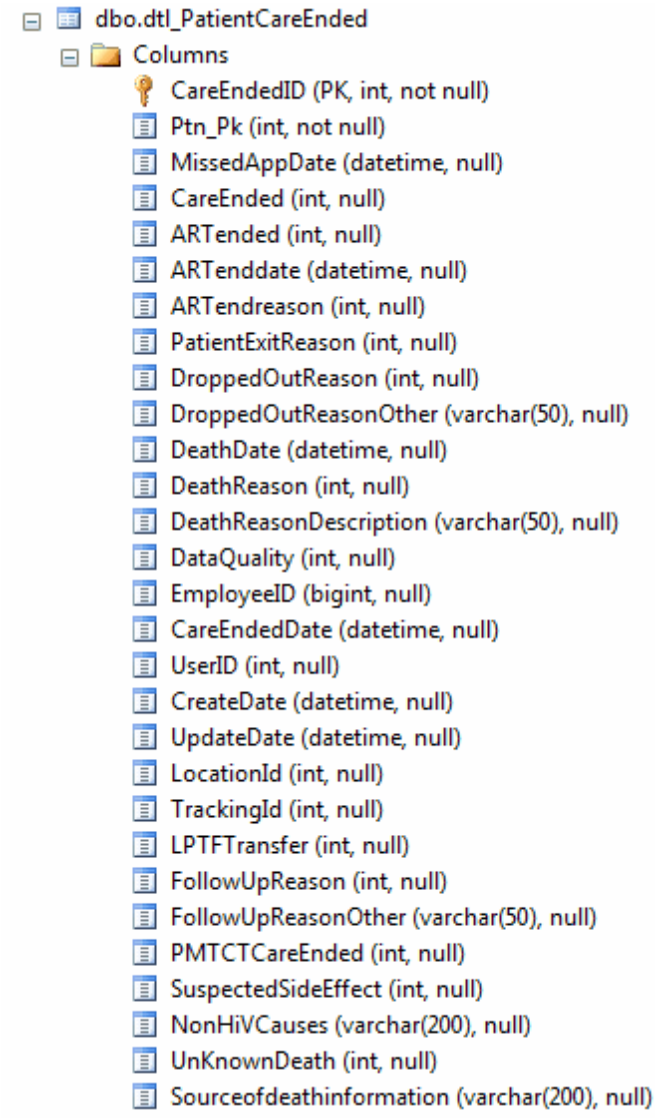

12.1.2 Universal Registration Form

One Registration for can be configured for the entire application. The idea is that this form is the universal registration for the facility. Different departments may have their own enrollment form which you would recreate as a dynamic form builder form.

The pre-defined registration fields are saved in two different tables - mst_patient and dtl patientcontact. Any new custom fields you create will be placed in a new table called DTL_FBCUSTOMFIELD_Patient_Registration.

There is a minimum set of fields that must be captured in order to register the patient into the system.

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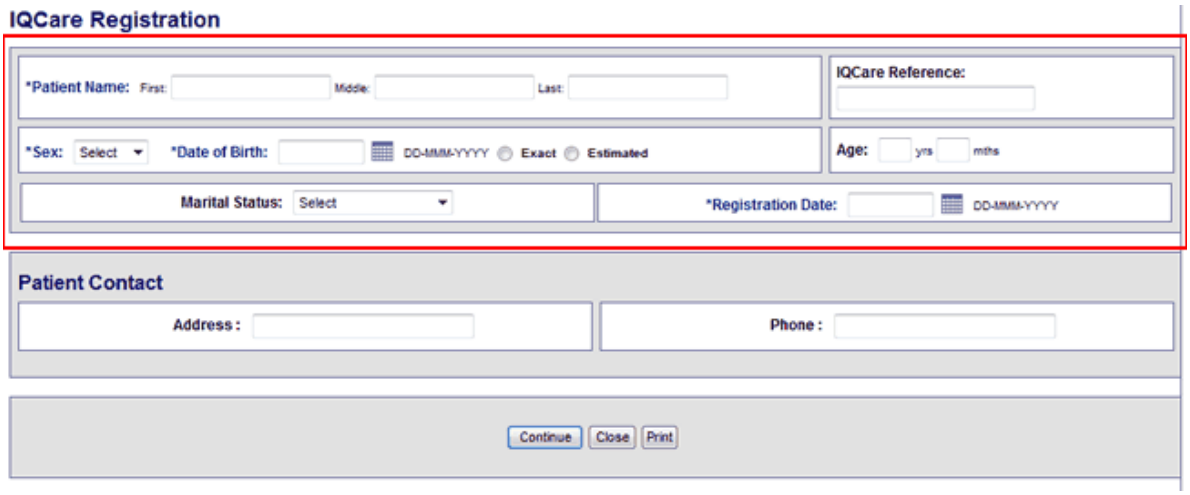

Display Label	Display Type	Table	Field	Required
Patient Name First	Text box	mst_Patient	FirstName	Yes
Patient Name Middle	Text box	mst_Patient	MiddelName	
Patient Name Last	Text box	mst_Patient	LastName	Yes
Sex	Select list	mst_Patient	Sex	Yes
Date of Birth	Date	mst_Patient	DOB	Yes
Exact, Estimated	Radio	mst_Patient	DobPrecision	
Age	Calculated			
Marital Status	Select list	mst_Patient	MaritalStatus	
Registration Date		mst_Patient	RegistrationDate	Yes

List of all registration form pre-defined fields

Pre-defined Field Name	PDFTableName	Control Type	BindTable
Village_Town_City	Dtl_PatientContacts	Select list	Mst_Village
District_County_Ward	Dtl_PatientContacts	Select list	Mst_District
Province_State	Dtl_patientContacts	Select list	Mst_Province
Parish	mst_patient	Text box	NULL
Home_based_care	mst_patient	Text box	NULL
PatientTelephonenumber	mst_patient	Text box	NULL
TreatmentSupportTelNumber	mst_patient	Text box	NULL

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Landmark	mst_patient	Text box	NULL
Sublocation	mst_patient	Text box	NULL
NearestHCenter	mst_patient	Text box	NULL
LocalCouncil	Mst_patient	Text box	NULL
Address	Mst_patient	Text box	NULL
EmergContactName	dtl_patientContacts	Text box	NULL
EmergContactRelation	dtl_patientContacts	Select list	mst_decode
EmergContactPhone	dtl_patientContacts	Text box	NULL
EmergContactAddress	dtl_patientContacts	Text box	NULL
Phone	mst_patient	Text box	NULL
TreatmentSupporterVillageTownCity	Dtl_PatientContacts	Select list	Mst_Village
TreatmentSupporterDistrictCountyWar	Dtl_PatientContacts	Select list	Mst_ward
TreatmentSupporterProvinceState	Dtl_PatientContacts	Select list	mst_Province
CareEntryPoint	mst_patient	Select list	mst_lptf
ClinicalTeamLeader	mst_patient	Select list	mst_employee

12.2 Common Static Forms Data Dictionary

The Adult Pharmacy, Paediatric Pharmacy, Follow up Education and Laboratory forms are common static forms that can be added to any technical area through special form linking.

The data dictionaries and business rules for these forms are found in this section.
Adult Pharmacy
Paediatric Pharmacy
Laboratory
Family Information

12.2.1 Adult Pharmacy

Non-paperless business rules for ALL drugs:	• If the user selects any drug, the strength, frequency, duration, quantity prescribed and quantity dispensed all need to be filled in.
Paperless business rules for ALL drugs:	• If the user selects any drug, the strength, frequency, duration, quantity prescribed with order by and order by date need to be filled in.If dispense quantity is filled in, then need to give dispense by and dispense by date.

Form Label	Database Table	Field Name	Business Rule	Required for Saving	Minimum Reporting	Minimum Clinical
First Name	mst_Patient	FirstName	Auto fill			
Last Name	mst_Patient	LastName	Auto fill			
ID - Patient Enrollment Number	mst_Patient	PatientEnrollmentID	Auto fill			
Existing Hosp/ Clinic #	mst_Patient	PatientClinicID	Auto fill			
Treatment Program	mst_Code, mst_Decode	CodeID	Select list [ART, PMTCT, PEP, Non-ART];Defaults	Yes		

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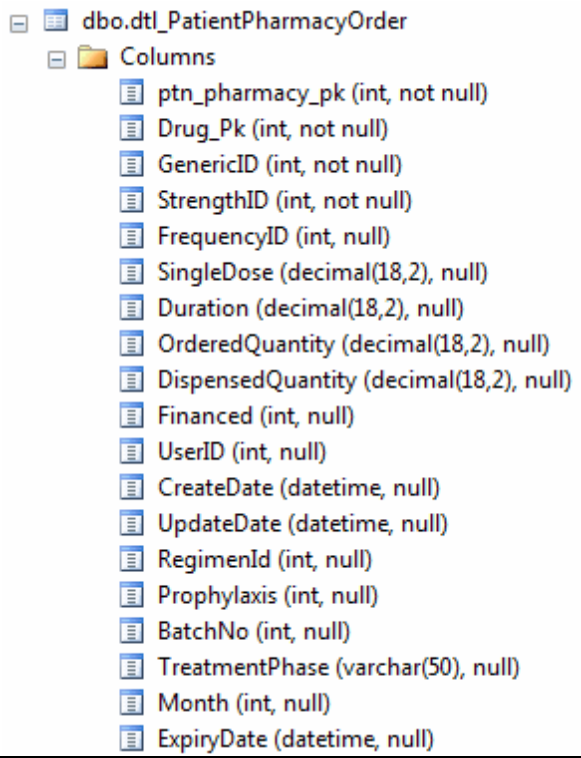
			to ART			
Period Taken			During pregnancy, during labor, post natal			
ARV Provider			Select list [Government, USG, Self-pay, Other]; Defaults to USG	Yes		
ARV Medications						
Regimen Line			If ART selected, then regimen line is a required field			

Dynamically created rows based on the selection by the user; each row saves to the dtl_PatientPharmacyOrder table.
IQCare captures the Strength, Frequency, Duration, Qty prescribed, Qty dispensed and if the drug is taken for prophylaxis.



OI Treatment and Other Medications

Dynamically created rows based on the selection by the user; each row saves to the dtl_PatientPharmacyOrder table.
IQCare captures the Strength, Frequency, Duration, Qty prescribed, Qty dispensed and if the drug is taken for prophylaxis.

TB Medication

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Dynamically created rows based on the selection by the user; each row saves to the dtl_PatientPharmacyOrder table. IQCare captures the Strength, Frequency, Duration, Qty prescribed, Qty dispensed and if the drug is taken for prophylaxis. For TB as well, the phase of treatment and the month of treatment						
Pharmacy Notes						
Location for notes by the clinician or pharmacist. Used mostly in paperless mode. Notes are saved into ord_PatientPharmacyOrder into the PharmacyNotes column (800 characters)						
Signature Block						
Prescribed by	ord_PatientPharmacyOrder	Orderedby				
Prescribed by Date	ord_PatientPharmacyOrder	OrderedbyDate	For paperless this is a required field for "ordering" drugs.	Yes for Paperless		
Dispensed by	ord_PatientPharmacyOrder	DispensedBy		Yes	Yes	Yes
Dispensed by Date	dtl_PatientPharmacyOrder	DespensedByDate	For paperless this must be filled in along with the quantity dispensed. For non-paperless, this is a required field. This is a key date because it is used for all pharmacy reporting (which is more accurate than the ordered by date.) This date = dtl_PatientArvTherapy:: PrescribedARVStartDate if the patient is starting therapy. This is indicated in the IE or FU forms.	Yes		
Signature	dtl_PatientPharmacyOrder	EmployeeID				
Adherance Counsellor Signature	dtl_PatientPharmacyOrder	Signature				
Print		Print	This button is used to take hard copy of the form. This is basically feature of			

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			paperless, but is implemented for non paperless too

12.2.2 Paediatric Pharmacy

Non-paperless business rules for ALL drugs:	• If the user selects any drug, the strength, frequency, duration, quantity prescribed and quantity dispensed all need to be filled in.
Paperless business rules for ALL drugs:	• If the user selects any drug, the strength, frequency, duration, quantity prescribed with order by and order by date need to be filled in.If dispense quantity is filled in, then need to give dispense by and dispense by date.

Form Label	Database Table	Field Name	Business Rule	Required for Saving	Minimum Reporting	Minimum Clinical
First Name	mst_Patient	FirstName	Auto fill			
Last Name	mst_Patient	LastName	Auto fill			
ID - Patient Enrollment Number	mst_Patient	PatientEnrollmentID	Auto fill			
Existing Hosp/ Clinic #	mst_Patient	PatientClinicID	Auto fill			
Treatment Program	mst_Code, mst_Decode	CodeID	Select list [ART, PMTCT, PEP, Non-ART];Defaults to ART	Yes		
Age (years)	Calculated		Auto fill If 2 years and 6 months, IQCare will display 2.6 years			
Date of Birth	mst_Patient	DOB	Auto fill			
Weight		Weight	Required field	Yes	Yes	Yes
Height		Height	Required field	Yes	Yes	Yes
Body Surface Area (m^2)	Calculated		BSA = sqrt (weight * height/3600), units=m^2			
Period Taken			During pregnancy, during labor, post natal			
ARV Provider			Select list [Government, USG, Self-pay, Other]; Defaults to USG	Yes		
ARV Medications						

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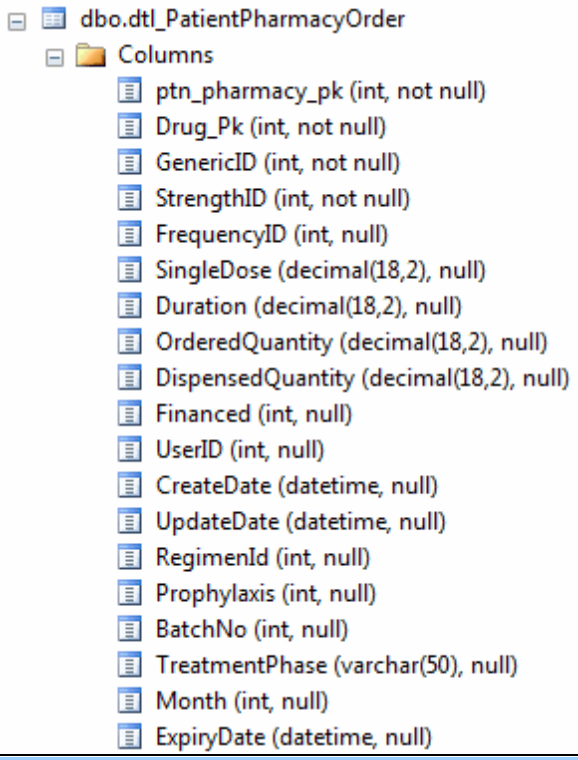
Regimen Line			If ART selected, then regimen line is a required field			

Dynamically created rows based on the selection by the user; each row saves to the dtl_PatientPharmacyOrder table.
IQCare captures the Strength, Frequency, Duration, Qty prescribed, Qty dispensed and if the drug is taken for prophylaxis.



OI Treatment and Other Medications

Dynamically created rows based on the selection by the user; each row saves to the dtl_PatientPharmacyOrder table.
IQCare captures the Strength, Frequency, Duration, Qty prescribed, Qty dispensed and if the drug is taken for prophylaxis.

TB Medication

Dynamically created rows based on the selection by the user; each row saves to the dtl_PatientPharmacyOrder table.
IQCare captures the Strength, Frequency, Duration, Qty prescribed, Qty dispensed and if the drug is taken for prophylaxis. For TB as well, the phase of treatment and the month of treatment

Pharmacy Notes

Location for notes by the clinician or pharmacist. Used mostly in paperless mode.
Notes are saved into ord_PatientPharmacyOrder into the PharmacyNotes column (800 characters)

Signature Block

Prescribed by	ord_PatientPharmacyOrder	Orderedby			
Prescribed by Date	ord_PatientPharmacyOrder	OrderedbyDate	For paperless this is a required field for	Yes for Paperless	

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			"ordering" drugs.			
Dispensed by	ord_PatientPharmacyOrder	DispensedBy		Yes	Yes	Yes
Dispensed by Date	dtl_PatientPharmacyOrder	DespensedByDate	For paperless this must be filled in along with the quantity dispensed. For non-paperless, this is a required field. This is a key date because it is used for all pharmacy reporting (which is more accurate than the ordered by date.) This date = dtl_PatientArvTherapy:: PrescribedARVStartDate if the patient is starting therapy. This is indicated in the IE or FU forms.	Yes		
Signature	dtl_PatientPharmacyOrder	EmployeeID				
Adherance Counsellor Signature	dtl_PatientPharmacyOrder	Signature				
Print		Print	This button is used to take hard copy of the form. This is basically feature of paperless, but is implemented for non paperless too			

12.2.3 Laboratory

Form Label	Database Table	Field Name	Business Rule	Required for Saving	Minimum Reporting	Minimum Clinical
First Name	**mst_Patient**	FirstName	Auto fill			
Last Name	**mst_Patient**	LastName	Auto fill			
ID - Country	**mst_Facility**	CountryID	Auto fill			
ID - POS#	**mst_Facility**	LocationID	Auto fill			
ID - Satellite #	**mst_Facility**	satelliteID	Auto fill			

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ID - Patient Enrollment Number	**mst_Patient**	PatientEnrollmentID	Auto fill			
Existing Hosp/Clinic #	**mst_Patient**	PatientClinicID	Auto fill			
Preclinic labs						
Labs to be done on						
Period Done			During pregnancy, during labor, During birth, post natal			
ARV Related labs (AIDSRelief to provide)						
HIV Serology/HIV Rapid Test	**dtl_PatientLabResult**	TestResults				
PCR			Positive, Negative			
CD4	**dtl_PatientLabResult**	TestResults				
CD4 Percent	**dtl_PatientLabResult**	TestResults				
RPR/VDLR						
FTA						
Viral Load	**dtl_PatientLabResult**	TestResults				
Viral Load undetectable	**dtl_PatientLabResult**	TestResults				
Store Plasma	**dtl_PatientLabResult**	TestResults				
HCT	**dtl_PatientLabResult**	TestResults				
Hb	**dtl_PatientLabResult**	TestResults				
WBC	**dtl_PatientLabResult**	TestResults				
WBC Diff (next 8 fields)	**dtl_PatientLabResult**	TestResults				
Neut	**dtl_PatientLabResult**	TestResults				
Neut%	**dtl_PatientLabResult**	TestResults				
Lymph	**dtl_PatientLabResult**	TestResults				
Lymph%	**dtl_PatientLabResult**	TestResults				
Mono	**dtl_PatientLabResult**	TestResults				
Mono%	**dtl_PatientLabResult**	TestResults				
Eosin	**dtl_PatientLabResult**	TestResults				
Eosin%	**dtl_PatientLabResult**	TestResults				
Platelets	**dtl_PatientLabResult**	TestResults				
AST/SGOT	**dtl_PatientLabResult**	TestResults				
ALT/SGPT	**dtl_PatientLabResult**	TestResults				
Creatinine	**dtl_PatientLabResult**	TestResults				
Amylase	**dtl_PatientLabResult**	TestResults				
Pregnancy	**dtl_PatientLabResult**	TestResults				
Malaria parasite	**dtl_PatientLabResult**	TestResults				
Serum Crypto. Ag	**dtl_PatientLabResult**	TestResults				
Sputum AFB1	**dtl_PatientLabResult**	TestResults				
Sputum AFB2	**dtl_PatientLabResult**	TestResults				
Sputum AFB3	**dtl_PatientLabResult**	TestResults				
Sputum Gram Stain	**dtl_PatientLabResult**	Testresults1				
Stool O/P	**dtl_PatientLabResult**	TestResults				
Stool Description	**dtl_PatientLabResult**	TestResults				
Urinalysis (next 11 fields)	**dtl_PatientLabResult**	TestResults				
Spec Grav	**dtl_PatientLabResult**	TestResults				
Glucose	**dtl_PatientLabResult**	TestResults				
Ketone	**dtl_PatientLabResult**	TestResults				
Protein	**dtl_PatientLabResult**	TestResults				
Leuk Est	**dtl_PatientLabResult**	TestResults				
Nitrate	**dtl_PatientLabResult**	TestResults				

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Blood	**dtl_PatientLabResult**	TestResults				
Urine Microscopic Blood	**dtl_PatientLabResult**	TestResults				
Urine Microscopic WBC	**dtl_PatientLabResult**	TestResults				
Urine Microscopic Bact	**dtl_PatientLabResult**	TestResults				
Urine Microscopic Casts	**dtl_PatientLabResult**	TestResults				
Urine Culture/ Sensitivity	**dtl_PatientLabResult**	Testresults1				
CSF Cryptococcal Ag	**dtl_PatientLabResult**	Testresults1				
CSF India Ink	**dtl_PatientLabResult**	TestResults				
CSF Gram Stain	**dtl_PatientLabResult**	TestResults				
CSF Culture	**dtl_PatientLabResult**	TestResults				
CSF Biochemistry Glucose	**dtl_PatientLabResult**	TestResults				
Cell count Rbcs	**dtl_PatientLabResult**	TestResults				
Cell count WBCs	**dtl_PatientLabResult**	TestResults				
Cell count Neutrophils	**dtl_PatientLabResult**	TestResults				
Cell count Lymphocytes	**dtl_PatientLabResult**	TestResults				
Protein	**dtl_PatientLabResult**	TestResults				
Chest X-Ray Result		Testresults1				
Additional labs (check if AIDSRelief is to provide for test)						
Additional Lab1 Type	**mst_LabType**	LabTypeName	List has been verified by IHV			
Additional Lab1 Result	**dtl_PatientLabResult**	Testresults1				
Additional Lab1 Financed	**dtl_PatientLabResult**	Financed				
Additional Lab2 Type	**mst_LabType**	LabTypeName				
Additional Lab2 Result	**dtl_PatientLabResult**	Testresults1				
Additional Lab2 Financed	**dtl_PatientLabResult**	Financed				
Additional Lab3 Type	**mst_LabType**	LabTypeName				
Additional Lab3 Result	**dtl_PatientLabResult**	Testresults1				
Additional Lab3 Financed	**dtl_PatientLabResult**	Financed				
Additional Lab4 Type	**mst_LabType**	LabTypeName				
Additional Lab4 Result	**dtl_PatientLabResult**	Testresults1				
Additional Lab4 Financed	**dtl_PatientLabResult**	Financed				
Additional Lab5 Type	**mst_LabType**	LabTypeName				
Additional Lab5 Result	**dtl_PatientLabResult**	Testresults1				
Additional Lab5 Financed	**dtl_PatientLabResult**	Financed				
Ordered by	**ord_PatientLabOrder**	OrderedbyName		Yes		
Ordered by Date	**ord_PatientLabOrder**	OrderedbyDate		Yes		
Reported by	**ord_PatientLabOrder**	ReportedbyName		Yes	Yes	Yes
Reported by Date	**ord_PatientLabOrder**	ReportedbyDate		Yes		

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Print		Print	This button is used to take hard copy of the form. This is basically feature of paperless, but is implemented for non paperless too

Laboratory Results Form Business Rules							
Form No.	Form Label	Database Table	Field Name	Business Rule	Required for Saving	Minimum Reporting	Minimum Clinical
	First Name	mst_Patient	FirstName	Auto fill			
	Last Name	mst_Patient	LastName	Auto fill			
	ID - Country	mst_Facility	CountryID	Auto fill			
	ID - POS#	mst_Facility	LocationID	Auto fill			
	ID - Satellite #	mst_Facility	satelliteID	Auto fill			
	ID - Patient Enrollment Number	mst_Patient	PatientEnrollmentID	Auto fill			
	Existing Hosp/Clinic #	mst_Patient	PatientClinicID	Auto fill			
1	Preclinic labs						
2	Labs to be done on						
3	ARV Related labs (AIDSRelief to provide)						
	HIV Serology	dtl_PatientLabResult	TestResults				
	CD4	dtl_PatientLabResult	TestResults				
	CD4 Percent	dtl_PatientLabResult	TestResults				
	Viral Load	dtl_PatientLabResult	TestResults				
	Viral Load undetectable	dtl_PatientL	TestRes				

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		abResult	ults				
	Store Plasma	dtl_PatientLabResult	TestResults				
	HCT	dtl_PatientLabResult	TestResults				
	Hb	dtl_PatientLabResult	TestResults				
	WBC	dtl_PatientLabResult	TestResults				
	WBC Diff (next 8 fields)	dtl_PatientLabResult	TestResults				
	Neut	dtl_PatientLabResult	TestResults				
	Neut%	dtl_PatientLabResult	TestResults				
	Lymph	dtl_PatientLabResult	TestResults				
	Lymph%	dtl_PatientLabResult	TestResults				
	Mono	dtl_PatientLabResult	TestResults				
	Mono%	dtl_PatientLabResult	TestResults				
	Eosin	dtl_PatientLabResult	TestResults				
	Eosin%	dtl_PatientLabResult	TestResults				
	Platelets	dtl_PatientLabResult	TestResults				
	AST/SGOT	dtl_PatientLabResult	TestResults				
	ALT/SGPT	dtl_PatientLabResult	TestResults				
	Creatinine	dtl_PatientLabResult	TestResults				
	Amylase	dtl_PatientLabResult	TestResults				
	Pregnancy	dtl_PatientLabResult	TestResults				
	Malaria parasite	dtl_PatientLabResult	TestResults				

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	Serum Crypto. Ag	dtl_PatientLabResult	TestResults				
	Sputum AFB1	dtl_PatientLabResult	TestResults				
	Sputum AFB2	dtl_PatientLabResult	TestResults				
	Sputum AFB3	dtl_PatientLabResult	TestResults				
	Sputum Gram Stain	dtl_PatientLabResult	Testresults1				
	Stool O/P	dtl_PatientLabResult	TestResults				
	Stool Description	dtl_PatientLabResult	TestResults				
	Urinalysis (next 11 fields)	dtl_PatientLabResult	TestResults				
	Spec Grav	dtl_PatientLabResult	TestResults				
	Glucose	dtl_PatientLabResult	TestResults				
	Ketone	dtl_PatientLabResult	TestResults				
	Protein	dtl_PatientLabResult	TestResults				
	Leuk Est	dtl_PatientLabResult	TestResults				
	Nitrate	dtl_PatientLabResult	TestResults				
	Blood	dtl_PatientLabResult	TestResults				
	Urine Microscopic Blood	dtl_PatientLabResult	TestResults				
	Urine Microscopic WBC	dtl_PatientLabResult	TestResults				
	Urine Microscopic Bact	dtl_PatientLabResult	TestResults				
	Urine Microscopic Casts	dtl_PatientLabResult	TestResults				
	Urine Culture/Sensitivity	dtl_PatientLabResult	Testresults1				
	CSF Cryptococcal Ag	dtl_PatientLabResult	Testresults1				

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	CSF India Ink	dtl_PatientLabResult	TestResults				
	CSF Gram Stain	dtl_PatientLabResult	TestResults				
	CSF Culture	dtl_PatientLabResult	TestResults				
	CSF Biochemistry Glucose	dtl_PatientLabResult	TestResults				
	Cell count Rbcs	dtl_PatientLabResult	TestResults				
	Cell count WBCs	dtl_PatientLabResult	TestResults				
	Cell count Neutrophils	dtl_PatientLabResult	TestResults				
	Cell count Lymphocytes	dtl_PatientLabResult	TestResults				
	Protein	dtl_PatientLabResult	TestResults				
	Chest X-Ray Result		Testresults1				
4	Additional labs (check if AIDSRelief is to provide for test)						
	Additional Lab1 Type	mst_LabType	LabTypeName	List has been verified by IHV			
	Additional Lab1 Result	dtl_PatientLabResult	Testresults1				
	Additional Lab1 Financed	dtl_PatientLabResult	Financed				
	Additional Lab2 Type	mst_LabType	LabTypeName				
	Additional Lab2 Result	dtl_PatientLabResult	Testresults1				
	Additional Lab2 Financed	dtl_PatientLabResult	Financed				
	Additional Lab3 Type	mst_LabType	LabTypeName				
	Additional Lab3 Result	dtl_PatientLabResult	Testresults1				

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	Additional Lab3 Financed	dtl_PatientLabResult	Financed				
	Additional Lab4 Type	mst_LabType	LabTypeName				
	Additional Lab4 Result	dtl_PatientLabResult	Testresults1				
	Additional Lab4 Financed	dtl_PatientLabResult	Financed				
	Additional Lab5 Type	mst_LabType	LabTypeName				
	Additional Lab5 Result	dtl_PatientLabResult	Testresults1				
	Additional Lab5 Financed	dtl_PatientLabResult	Financed				
	Ordered by	ord_PatientLabOrder	OrderedbyName		Yes		
	Ordered by Date	ord_PatientLabOrder	OrderedbyDate		Yes		
	Reported by	ord_PatientLabOrder	ReportedbyName		Yes	Yes	Yes
	Reported by Date	ord_PatientLabOrder	ReportedbyDate		Yes		
	Print		Print	This button is used to take hard copy of the form. This is basically feature of paperless, but is implemented for			

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				non paperless too			

12.2.4 Family Information

Form Label	Database Table	Field Name	Business Rule	De-identified Field	Required Field
First Name	mst_Patient	FirstName	Auto filled		
Last Name	mst_Patient	LastName	Auto filled		
ID - Patient Enrollment Number	mst_Patient	PatientEnrollmentID	Auto filled		
Existing Hosp/ Clinic #	mst_Patient	PatientClinicID	Auto filled		
Registered at this clinic	dtl_FamilyInfo	RegistrationNo	Yes/No; If Yes, then Find Patient button displays and fields are populated with data from the database. If No, then manually fill in the fields		
Relative First Name	dtl_FamilyInfo	RFirstName	This field is auto filled if patient is existing in db; otherwise manually entered	Yes	Yes
Relative Last Name	dtl_FamilyInfo	RLastName	This field is auto filled if patient is existing in db; otherwise manually entered Can not have duplicate relative name	Yes	Yes
Sex	dtl_FamilyInfo	Sex	This field is auto filled if patient is existing in db; otherwise manually entered		Yes
Age - years, months	dtl_FamilyInfo	AgeMonth AgeYear	These fields are auto filled if patient is existing in db; otherwise manually entered		Yes
Relationship Type	dtl_FamilyInfo	RelationshipType	Select list; This select list is a customized, restricted list		Yes

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Birth/Marriage Date	dtl_FamilyInfo	RelationshipDate	If Child or Spouse/Partner is selected in the Relationship field, then display this date field		
HIV Status	dtl_FamilyInfo	HivStatus	Only display this field if Existing Patient = No Select List options: Positive, Negative, Unknown		Yes
HIV Care Status	dtl_FamilyInfo	HivCareStatus	Only display this field if Existing Patient = No Select List options: In HIV Care, On ART, Not in HIV Care, Died, Unknown		Yes
Print		Print	This button is used to take hard copy of the form. This is basically feature of paperless, but is implemented for non paperless too		

12.2.5 Follow up Education

The follow up education, support and preparation for ARV therapy form is found on most MOH HIV Care Cards.

The form lists can be configured in Customized lists -
- Counselling Topic
- Counselling Type
- Counselling Type-Counselling Topic (links the two lists)

Form Label	Data Entry Type	IQCare Table	IQCare Field
Topic	Select list	dtl_FollowupEducation	CouncellingTypeId
Subtopic	Select list	dtl_FollowupEducation	CouncellingTopicId
Date	date	dtl_FollowupEducation	VisitDate
Comments	Text	dtl_FollowupEducation	OtherDetail

12.3 HIV Care Static Forms Data Dictionary

The data dictionary and business rules for all the AIDSRelief forms are available.

Enrollment
Initial Evaluation

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Family Information
Adult Pharmacy
Paediatric Pharmacy
Laboratory
Non-ART Follow-up
Care Tracking
Home Visit

12.3.1 Custom Reports Field Groups - AR

Updated July 27, 2009

Field Groups:	Care Ended	Clinical Status	Custom Fields	Employee	Facility Information
DB View Name:	*Rpt_PatientCare Ended*	*Rpt _PatientClinicalStatus*	*Rpt _CustomField_Results*	*Rpt _Employee*	*Rpt _Facility*
Data Fields:	ART Ended	Clinical Signature	Custom Field Label	Employee Designation	App Grace Period
	ART Ended Date	Date HIV Diagnosis	Custom Field Result	Employee First Name	Country Num
	ART Ended Reason	Disclosure		Employee Last Name	Currency
	Care Ended	Disclosure Relationship	*(All of the custom fields created*	Employee Name	Facility Name
	Care Ended Date	HIV Diagnosis Verified	*by the site will be in the field*		LPTF Num
	Care Ended Signature	LMP	*select list)*		PEPFAR Start Date
	Death Date	Pregnant			Satellite Num
	Death Reason				
	Death Reason Description				
	LPTF Transferred To				
	Stopped Reason				
	Stopped Reason Other				
	Patient Exit Reason				

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Field Groups:	Family Information	HIV Information	HIV Previous Care	Laboratory	OIsorAIDSDefiningIllnesses
DB View Name:	*Rpt_Family Information*	*Rpt _PatientHIVOther*	*Rpt _PatientHIVPreviousCare*	*Rpt _Laboratory*	*Rpt_OIsorAIDSDefinglInesse*

					s
Data Fields:	Family Member Name	Enrollment Support Group	Ever Been on ART	AIDSRelief Financed Lab	DateOfDiseasse
	HIV Care Status	HIV Barrier	Previous ART Sponsor	Checked by Date	DefiningIllness
	HIV Status	HIV Disclosure	Previous ART Sponsor Other	Checked by Name	DefiningIllnessDescription
	Registered	HIV Disclosure Other	Previous Care Type	Lab Department	
	Relationship	HIV Status	Previous Care Type Other	Lab Ordered by	
	Relationship date	Num Household HIV Died	Previous HIV Care	Lab Ordered	

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				by Date	
	Relative Age (Month)	Num Household HIV Positive	Previous Medical Records	Lab Test	
	Relative Age (Year)	Num Household HIV Tested		Lab Unit	
	Relative Sex	Referred From Inpatient Ward		Max Boundary Value	
		Referred From		Min Boundary Value	
		Support Group Name		Pre Clinic Lab Date	
				Reported by	
				Reported by Date	
				Test Results (text or numeric)	

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Field Groups:	Patient Adherence	Patient Appointment	Patient Assessment and Therapy	Patient Contacts
DB View Name:	*Rpt _PatientAdherence*	*Rpt _PatientAppointment*	*Rpt _PatientAssessment Rpt _PatientTherapy*	*Rpt _PatientContacts*
Data Fields:	Adherence Code	Appointment Date	AIDSRelief ARV Start Date	Emergency Contact Address
	Adherence Other Details	Appointment Provider	Assessment Category	Emergency Contact Discuss Status
	Adherence Support Group	Appointment Purpose	Assessment Description - IE	Emergency Contact Know s HIV Status
	Herbal Meds	Appointment Status	Assessment Name	Emergency Contact Name
	Interrupted Date		Therapy Plan	Emergency Contact Phone
	Interrupted Num Days		Therapy Reason Code	Emergency Contact Relationship
	Missed Last Week			
	Missed Last Month			
	Num DOT Per Week			
	Num Home Visits Per Week			
	Stopped Date			

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	Stopped Num Days			

Field Groups:	Patient Demographics	Patient Symptoms	Pharmacy	Previous Regimen
DB View Name:	*Rpt _PatientDemographics*	*Rpt _PatientSymptoms*	*Rpt _PharmacyDispense*	*Rpt _PatientHivPrevCareIE*
Data Fields:	Age	Symptom Category	AIDSRelief Financed Drug	Allergy Name
	Age at Enrollment	Symptom Description	Dispensed By	Allergy Other Details
	AIDSRelief ART Start Date	Symptom Name	Dispensed By Date	CD4 % Prior to ARVs
	Current ART Regimen		Dispensed Quantity	CD4 Prior to ARVs
	Current ART Regimen Start Date		Dose	CD4 Prior to ARVs Date
	Date of Birth		Drug Abbreviation	Current ART - IE
	Distance Travelled (Km)		Drug Name	Current ART Start Date - IE

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	District		Drug Type	Long Term Meds Other - 1
	Education Level		Duration	Long Term Meds Other Desc - 1
	Employment Status		Frequency	Long Term Meds Other Desc - 2
	Enrollment Date		Generic Drug Name	Long Term Meds Other Desc - 3
	Existing Hosp/Clinic #		Hold Medicine	Long Term Meds Sulfa
	Literacy		Order Type {text translation}	Long Term Meds Sulfa Desc
	Local Council		Ordered Quantity	Long Term TB Med Desc
	Marital Status		Pharmacy Ordered By	Long Term TB Medication
	Monthly Income		Pharmacy Ordered By Date	Long Term TB Start Date
	Num Children		Regimen	Low est CD4 - IE
	Num People In Household		Treatment Program	Low est CD4 Date - IE
	Occupation		ARV Provider	Low est CD4 Percent - IE
	Patient Address		Regimen Code	Most Recent CD4 - IE
	Patient Enrollment #		OI Treatment	Most Recent CD4 Date - IE
	Patient First Name			Most Recent CD4 Percent - IE
	Patient Last Name			Most Recent Viral Load Date - IE
	Patient Location			Most Recent Viral Load - IE
	Patient Name			Previous ARV Regimen
	Patient Phone			Previous ARV Regimen Months
	Patient Status			Previous ARV Regimen1 Current
	Province			Previous ARV Regimen1 Months
	Sex			Previous ARV Regimen1 Name
	Status Changed Date			
	Time Travelled			
	Travel Units			

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	Village			

Field Groups:	Previous Regimen (continued)	Therapy and Adherence	Visit	Vital Signs	WAB & WHO Stage
DB View Name:	*Rpt _PatientHivPrevCareIE*	*Rpt _AdherenceMissedReason*	*Rpt _Visit*	*Rpt _PatientVitals*	*Rpt _PatientStage*
Data Fields:	Previous ARV Regimen2 Current	Reason Category	Treatment Location	BP Diastolic	WAB Stage
	Previous ARV Regimen2 Months	Reason Code	Visit Type	BP Systolic	WHO Stage
	Previous ARV Regimen2 Name		Visit Date	Heart Rate	
	Previous ARV Regimen3 Current			Height (cm)	
	Previous ARV Regimen3 Months			Pain	
	Previous ARV Regimen3 Name			Respiratory Rate	
	Previous ARV Regimen4 Current			Temp (°C)	
	Previous ARV Regimen4 Months			Weight (kg)	
	Previous ARV Regimen4 Name				
	Single Dose NVP				
	Single Dose NVP Date-1				
	Single Dose NVP Date-2				

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12.3.2 Custom Lists by HIV Care Static Forms

(A=add terms; I=Inactivate terms; U=updated terms)

See Restricted and Unrestricted Lists for more information.

List Type	Action Allowed	Form/ Display Type	Select List Name on Form
Restricted	A	Enrollment Multi select list	Potential Barriers to Enrollment Successful HIV Care
Restricted	A	Enrollment Multi select list	HIV/AIDS Care Types
Restricted	A	Enrollment Multi select list	ART Sponsor
Restricted	A	Enrollment Multi select list	HIV Disclosure Status
Restricted	A	Enrollment Multi select list	Barriers to HIV Care
Restricted	A	Enrollment Multi select list	HIV/AIDS Care Types
Restricted	A	Enrollment Multi select list	Patient Referred
Restricted	A	Family Information Select list	HIV Care Status
Restricted	A	Family Information Select list	Patient Relation Type
Restricted	A	IE Multi select list	Presenting Complaint(s)
Restricted	A	IE ART FU Non ART FU	OI or AIDS Defining Illness

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		Multi select list	
Restricted	A	IE ART FU Select list	Therapy Change Code (Change/Stop regimen reason code)
Restricted	A	ART FU Multi select list	Adherence Codes
Restricted	A	ART FU Multi select list	ARV Side Effects
Restricted	A	Adult Pharmacy Paediatric Pharmacy Multi select list	ARV Providers
Restricted	A	Pharmacy Select list	HIV Care Type
Restricted	A	Care Ended Select list	Stopped Reason
Unrestricted	A,I,U	Enrollment Care Tracking Select list	LPTF Patient Transfer
Unrestricted	A, I, U	Enrollment Select list	Village/Town/City Name
Unrestricted	A, I, U	Enrollment Select list	District/County/ Ward
Unrestricted	A, I, U	Enrollment Select list	Province/ State
Unrestricted	A, I, U	Enrollment Select list	Emergency Contact Relationship
Unrestricted	A, I, U	Enrollment Radio button	Marital Status
Unrestricted	A, I, U	Enrollment Select list	Educational Level
Unrestricted	A, I, U	Enrollment Select list	Employment Status

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Unrestricted	A, I, U	All forms (Displayed as part of employee name, provider, etc.)	Employee Designation
Unrestricted	A, I, U	System Select list categorized by Employee Designation	Employee Name
Unrestricted	A, I, U	IE (Long Term Medications and Sulfa drugs) Adult and Ped Pharmacy (OI Treatment and Other Medications) Dialog with as-you-type search capability	Other Mediation – Drug Master
Unrestricted	A, I, U	System Select list	Scheduler – Appointment purpose
Unrestricted	A, I, U	Laboratory Select list or Dialog with as-you-type search capability	Additional Labs
Unrestricted	A, I, U	Laboratory Configuration found in the Customize List section Select list	Laboratory Units
Unrestricted	A, I, U	Care Tracking	LPTF Transferred To
Does not apply	I, U	Laboratory Units – non editable field Boundary values for test results for field level validation	Configure Lab Units

12.3.3 Enrollment

Enrollment Form Business Rules								

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Form No.	Form Label	Database Table	Field Name	Business Rule	De-identified Field	Required for Saving	Minimum Reporting	Minimum Clinical
1	First Name	mst_Patient	FirstName		Yes	Yes	Yes	Yes
1	Last Name	mst_Patient	LastName	Alert the User if the System already has a patient with the entered last name.	Yes	Yes	Yes	Yes
2	Visit Date	ord_Visit	VisitDate	Date on which the patient came into the clinic. No future dates allowed. No default required (ie don't default to today's date, leave blank. Because the forms get filled in the following day or later, the data entry person would have to change the date in any case.)		Yes	Yes	Yes
3	ID - Country	mst_Facility	CountryID	Auto filled for all forms - driven by the software set up		Yes	Yes	
3	ID - LPTF#	mst_Facility	PosID	Auto filled for all forms - driven by the software set up		Yes	Yes	
3	ID - Satellite #	mst_Facility	SatelliteID	Auto filled for all forms - driven by the software set up		Yes	Yes	
3	ID - Patient Enrollment Number	mst_Patient	PatientEnrollmentID	This is the ID for the patient who enters into the AIDSRelief program Country, POS#, Satelite# are pre-set upon software configuration and pre-pends the Patient Enrollment number. The enrollment form is the only location this field is filled in for the patient. Once saved, then this field should not be editable, except by Users who have editing rights (as specified in a User Group).		Yes	Yes	

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4	Existing Hosp/ Clinic #	mst_Patient	PatientClinicID	Patient registration number for the clinic. This may or may not be available for the patient. This is can be alpha numberic. This is unique for a facility. The system will check for duplicates. The enrollment form is the only location this field is filled in for the patient. This is an editable field.				Yes
5	Sex	mst_Patient	Sex	Gender (sex) F= Female M= Male This is an editable field.		Yes	Yes	Yes
7	Date of Birth	mst_Patient	DOB			Yes	Yes	Yes
7	DOB Precision	mst_Patient	DobPrecision	Flag in database				
6	Age	Calculated		This field represents the current age of the patient and will change over time if the form is pulled up. Ages less than one year should be displayed as a decimal. For example, if a patient is 6 months old it should display as .5 years.				Yes
6	Age at Enrollment (years)	Calculated		The age on the enrollement form reprsesents the age of the pateint when they enrolled and should not change over time. Ages less than one year should be displayed as a decimal. For example, if a patient is 6 months old it should display as .5 years.				
new	Transfer in		Transfer in	This is a checkbox that indicates that the patient has transferred in from another location. If this is selected, a select list for LPTF transferred from displays				

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new	LPTF Transfer from		LPTF Transferred from	This field needs to be filled in if checkbox for Transfer in is selected. The list comes from the Patient Transfer custom list.				
8	Chief/ Local council	mst_Patient	LocalCouncil		Yes			
8	Village / Town/ City name	mst_Patient	VillageName	Custom list	Yes			
8	District / County/ Ward	mst_Patient	DistrictName	Custom list	Yes			
8	Province/ State	mst_Patient	Province	Custom list	Yes			
8	Residence/ Address/PO Box	mst_Patient	Address		Yes			
8	Phone number	mst_Patient	Phone		Yes			
9	Emergency Contact Name	dtl_PatientContacts	EmergContactName		Yes			
9	Emergency Contact Relationship	dtl_PatientContacts	EmergContactRelation					
9	Emergency Contact Phone Number	dtl_PatientContacts	EmergContactPhone	This information is taken on the Enrollment form and should be presented again in the Contact & Care Tracking form, with the label "Guardian Contact Informaiton" Field to remove for de-identified export	Yes			

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9	Emergency Contact Address Field to remove for de-identified export	dtl_PatientContacts	EmergContactAddress		Yes			
10	Does contact person know your HIV status?	dtl_PatientContacts	EmergContactKnowsHIVStatus					
11	If no, can we discuss your status with this contact person?	dtl_PatientContacts	DiscussStatus					
12	Marital status	mst_Patient	MaritalStatus	Custom select box; Comes from the Marital Status Master				
13	Educational Level	mst_Patient	EducationLevel	Custom select box; Comes from the Education Master				
14	Literacy	mst_Patient	Literacy					
15	Have you ever received care for HIV/AIDS?	dtl_HIVAidsCareTypes	PrevHIVCare					
15	If yes,	dtl_Patient	list of					

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	specify type	HivPrevCareEnrollment	previous care types					
15	Previous HIV Care - Other	dtl_PatientHivPrevCareEnrollment	prevHIVTypeOther					
16	Have you ever been on ARTs?	dtl_PatientHivPrevCareEnrollment	PrevART				Yes	
16	If yes, specify sponsor	dtl_PatientHivPrevCareEnrollment	list of sponsors					
16	Previous ARTs Sponsor Other	dtl_PatientHivPrevCareEnrollment	PrevARTSOtherSpecs					
16a	If yes, can we have a copy of your medical records today?	dtl_PatientHivPrevCareEnrollment	PrevMedRecords				Yes, If "Have you ever been on ART" = Yes	
17	Employment status	dtl_PatientHouseHoldInfo	EmploymentStatus					
17	Occupation	dtl_PatientHouseHoldInfo	Occupation					
18	Monthly Income	dtl_PatientHouseHoldInfo	MonthlyIncome	Show currency label (as per configuration) and add commas and decimals				
19	How many children do you have?	dtl_PatientHouseHoldInfo	NumChildren					

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20	How many people are in your household?	dtl_PatientHouseHoldInfo	NumPeopleHousehold					
21	Distance travelled from residence to point of service	dtl_PatientHouseHoldInfo	DistanceTravelled					
22	How long did it take you to get here today? Time	dtl_PatientHouseHoldInfo	TimeTravelled					
22	How long did it take you to get here today? Units	dtl_PatientHouseHoldInfo	TravelledUnits	Days, Hours, Minutes				
24	HIV Status	dtl_PatientHivOther	HIVStatus					
25	HIV disclosure status	dtl_PatientHivOther	HIVDisclosure					
25	HIV disclosure status Other	dtl_PatientHivOther	HIVDisclosureOther					
26	How many member(s) of your house	dtl_PatientHivOther	NumHouseholdHIVTest					

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	hold do you know have done an HIV Test?							
26b	How many member(s) of your household do you know have tested positive for HIV ?	dtl_PatientHivOther	NumHouseholdHIVPositive					
27	How many member(s) of your household do you know are deceased from HIV?	dtl_PatientHivOther	NumHouseholdHIVDied					
28	Membership in HIV support group	dtl_PatientHivOther	Support Group					
28	If yes, specify	dtl_PatientHivOther	SupportGroupName					
29	Patient Referred from:	mst_Patient	ReferredFrom					
	Potential Barriers to	dtl_PatientHivOther	List of barriers (BarrierFinancial,					

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	successful HIV care		BarrierFearDisclosure, etc.)					
	Potential Barriers to successful HIV care - Notes	dtl_PatientHivOther						
	Interviewer	mst_Patient	EmployeeID					
	Print		Print	This button is used to make a hard copy of the form. This is basically feature of paperless, but is implemented for non paperless too				

12.3.4 Initial Evaluation

Initial Evaluation Business Rules								
General Rules:								
If a patient is reactivated, the physician can fill out a new IE form (or a FU form); and therefore there can be more than one instance of the IE form in IQCare								
Paperless: ARV Therapy is not a required field								
Form No.	**Form Label**	**Database Table**	**Field Name**	**Business Rule**	**De-identified Field**	**Required for Saving**	**Minimum Reporting**	**Minimum Clinical**
1	First Name	mst_Patient	FirstName	Auto filled		Yes	Yes	Yes
1	Last Name	mst_Patient	LastName	Auto filled		Yes	Yes	Yes
2	Visit Date	ord_Visit	VisitDate	Date on which the patient came into		Yes	Yes	Yes

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				the clinic. No future dates allowed - like 2020				
3	ID - Country	mst_Facility	CountryID	Auto filled		Yes	Yes	
3	ID - LPTF#	mst_Facility	PosID	Auto filled		Yes	Yes	
3	ID - Satellite #	mst_Facility	satelliteID	Auto filled		Yes	Yes	
3	ID - Patient Enrollment Number	mst_Patient	PatientEnrollmentID	Auto filled		Yes	Yes	
3	Existing Hosp/ Clinic #	mst_Patient	PatientClinicID	Auto filled		Yes		Yes
5a	Date of HIV diagnosis	dtl_PatientClinicalStatus	DateHIVDiagnosis					Yes
5b	Diagnosis verified	dtl_PatientClinicalStatus	HIVDiagnosisVerified	It's a yes, no field				
6	Disclosed	dtl_PatientClinicalStatus	Disclosure	Although this is a similar question to the HIV Disclosure status quesiton on the Enrollment form, it is handled separately.				
6	Who to	dtl_PatientClinicalStatus	DisclosureName	This should be a select box with the same options as for the field: dtl_PatientHivOther::HIVDisclosure Because this is a text box on the IE form, there is a possiblilty that different information may be entered than in the select box. The data entry person have to				

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				update the master table appropriately.				
7	Pregnant	dtl_PatientClinicalStatus	Pregnant	The field should only display or be editable (can gray out) if the patient has Gender=female This should be defaulted to "No"			Yes - if female	Yes - if female
7	LMP	dtl_PatientClinicalStatus	LMP	LMP= Last Menstral Period				Yes - if female
	Presenting Complaints							
8	Presenting Complaints	dtl_PatientSymptoms	SymptomID	Default the UI to None; if other complaints are selected, None becomes de-selected.				
	Medical History							
10	Medical History - None, Liver, Kidney, Anaemia, etc.	dtl_PatientDisease	DiseasePresent	No UI defaults 1) If None is selected, then Liver, kidney, anemia and drug/alcohol abuse are given the answer of “none’ or null; 2) If one or more diseases are selected, and the others are not filled out, then the others get "none". (or only those that get filled in reside in the databae with the assumption that if it is not captured,				None, filled in data, or Not documented

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				then the value is "none") 3) If nothing is selected, then the Not Documented button must be selected.				
10	Disease	dtl_PatientDisease	Disease_Pk					
10	Disease year	dtl_PatientDisease	DateOfDisease	For each new year, the current year is added to the list.				
11	Allergies -- None	dtl_PatientAllergy	AllergyID					
	Allergies -- Not documented							
11	Allergies - Sulfa drugs	dtl_PatientAllergy	AllergyID					None, Yes, or Not documented
11	Allergies -- Other (specify)	dtl_PatientAllergy	AllergyID					
12	Long Term Medications - Sulfa/ TMP	dtl_PatientHivPrevCareIE	LongTermMedsSulfa					None, Yes, or Not documented
12	Long Term Medications -	dtl_PatientHivPrevCareIE	LongTermTBMed					

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	TB Rx (specify)							
12	Long Term Medications - TB Date	dtl_PatientHivPrevCareIE	LongTermTBStartDate					
12	Long Term Medications - Other1, Other2 Description	dtl_PatientHivPrevCareIE	longTermMedsOther1Desc	Two "other long term meds" available				
	HIV Related History							
13	Lowest CD4 Count	dtl_PatientHivPrevCareIE	PrevLowestCD4	Units = c/mm3				
13	Lowest CD4 Percent	dtl_PatientHivPrevCareIE	PrevLowestCD4Percent	Whole number, no decimals; should not exceed 99%				
13	Lowest CD4 Date	dtl_PatientHivPrevCareIE	PrevLowestCD4Date					
13b	CD4 prior to starting ARV Count	dtl_PatientHivPrevCareIE	PriorARVsCD4					
13b	CD4 prior to starting ARV Percent	dtl_PatientHivPrevCareIE	PrevARVScd4pRECENT					
13b	CD4 prior to starting ARV Date	dtl_PatientHivPrevCareIE	PriorARVsCD4Date					

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14	Most recent CD4 Last CD4 Count	dtl_PatientHivPrevCareIE	MostRecentCD4	Check that this date is before the visit date.				
14	Most Recent CD4 Percent	dtl_PatientHivPrevCareIE	MostRecentCD4Percent	Whole number, no decimals; should not exceed 99%				
14	Most recent CD4 Date Last CD4 Count Date	dtl_PatientHivPrevCareIE	MostRecentCD4Date					
15	Pre-therapy Viral Load Last Viral Load	dtl_PatientHivPrevCareIE	MostRecentViralLoad	Whole number, no decimals				
15	Pre-therapy Viral Load Date Last Viral Load Date	dtl_PatientHivPrevCareIE	MostRecentViralLoadDate					
16	ARV exposure - None	dtl_PatientHivPrevCareIE	PrevARVExposure	Do not default UI to None. If None has be select and any other of the fields in this section are filled in, None becomes unchecked. If other fields are filled in and None is then checked, an alert message appear notifying the			Yes Either "none", "single dose NVP" or "ARVs" must be	Yes - if none other in this section selected

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				user that the fields will be cleared.			selected	
16	Historical ART	dtl_PatientHivPrevCareIE	Previous ART	Use of drug helper which allows the User to select the drugs that make up the regimen		Yes if Previous ARV exposure not equal to "None"	Yes if Previous ARV exposure not equal to "None"	Yes if Previous ARV exposure not equal to "None"
16	Historical Start Date	dtl_PatientHivPrevCareIE		mm/yy			Yes We need to know whether they have been on ART for the last three months	
16	Previous Single dose NVP	dtl_PatientHivPrevCareIE	PrevSingleDoseNVP	Check box which opens two date fields			Yes if Previous ARV exposure not equal to "None"	Yes if Previous ARV exposure not equal to "None"
16	Previous Single dose NVP	dtl_PatientHivPrevCareIE	PrevSingleDoseNVP	mm/yy				

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	Date1		Date					
16	Previous Single dose NVP Date2	dtl_PatientHivPrevCareIE	PrevSingleDoseNVPDate	mm/yy				
16	Regimen (Previous 1st Regimen Name)	dtl_PatientHivPrevCareIE	PrevARVRegimen1Name	Select from drug list				
16	Regimen (Previous 1st Regimen Months)	dtl_PatientHivPrevCareIE	PrevARVRegimen1Months					
16	Regimen (Previous 2nd Regimen Name)	dtl_PatientHivPrevCareIE	PrevARVRegimen2Name	Select from drug list				
16	Regimen (Previous 2nd Regimen Months)	dtl_PatientHivPrevCareIE	PrevARVRegimen2Months					
16	Regimen (Previous 3rd Regimen Name)	dtl_PatientHivPrevCareIE	PrevARVRegimen3Name	Select from drug list				
16	Regimen (Previous 3rd Regimen Months)	dtl_PatientHivPrevCareIE	PrevARVRegimen3Months					

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16	Regimen (Previous 4th Regimen Name)	dtl_PatientHivPrevCareIE	PrevARVRegimen4Name	Select from drug list				
16	Regimen (Previous 4th Regimen Months)	dtl_PatientHivPrevCareIE	PrevARVRegimen4Months					
	HIV Associated Conditions							
	None, Pulmonary TB, ExtrapulmonaryTB, etc…	mst_HivDisease, dtl_PatientDisease	Disease_pk, DiseaseName	No UI defaults; Not document button required Pulmonary Smear + and Pulmonary Smear - separated out				Yes [none, conditions entered or not documented must be filled in]
	Physical Exam							
	Temp (Degrees C)	dtl_PatientVitals	Temp (deg C)	Field level validation boundaries: 30.0-50.0				
	RR (cpm)	dtl_PatientVitals	RR	Field level validation boundaries: 4-100				
	HR (bpm)	dtl_PatientVitals	HR	Field level validation boundaries: 30-200				
	BP Systolic	dtl_PatientVitals	BPSystolic	Field level validation boundaries: 50-250				

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	(mm/ Hg)							
	BP Diastolic (mm/ Hg)	dtl_PatientVitals	BPDiastolic	Field level validation boundaries: 30-150				
	Ht (cm)	dtl_PatientVitals	Height	Field level valdiation boundaries: 0-250				Yes
	Wt (kg)	dtl_PatientVitals	Weight	Field level validation boundaries: 0-225				Yes
	Pain	dtl_PatientVitals	Pain	Pain is on a scale of 1 to 10.				
	WAB Stage	dtl_PatientStage	WAB Stage	[Working, Ambulatory, Bedridden]				Yes
	WHO Stage	dtl_PatientStage	WHO Stage	I, II, III, IV]				Yes
	Assessment							
	Clinical Assessment - Initial Evaluation	dtl_PatientAssessment	AssessmentID	Assessment options: No illness found, HIV-related illness/OI, Non-HIV-related illness				Yes
	Clinical Assessment Notes	dtl_PatientAssessment	Description					
	Treatment Plan							
	Treatment Plan - Initial Evaluation	dtl_PatientAssessment	AssessmentID	Plan options: Lab evaluation/TB screen, OI Prophylaxis/ treatment, Treatment Preparation, Other				
	Treatment Plan Notes	dtl_PatientAssessment	Description					
	ARV Therapy							

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	Treatment not indicated now	dtl_PatientArvTherapy	TherapyPlan	For non-paperless, this is a required field; For paperless, this is not a requied field.		Yes, for non-paperless		
	Continue Current	dtl_PatientArvTherapy	TherapyPlan					
	Restart Treatment	dtl_PatientArvTherapy	TherapyPlan					
	Start New Treatment	dtl_PatientArvTherapy	TherapyPlan					
	Change regimen reason code	dtl_PatientArvTherapy	TherapyReasonCode	If currARVTherapy=Change treatment then TherapyReasonCode is required				
	Stop regimen reason code	dtl_PatientArvTherapy	TherapyReasonCode	If currARVTherapy=Stop treatment then TherapyReasonCode is required				
	Appointment Scheduling							
	When is the patient's next appointment?	Dtl_Patientappointment	Appdate	This needs to be tied into the schedule. The date should be automatically calculated based on appointment period.				
	Next appointment date	Dtl_patientappointment	Appdate	The date can be entered directly. If a date is entered, then appPeriod is Null.			Yes	
	Appointment Reason	Dtl_patientappointment	AppReason	This is a new field: reasons are “Follow up”; “Lab test”; and				

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				"Treatment Preparation"				
	Signature	dtl_PatientClinicalStatus	signature					
	Print		Print	This button is used to take hard copy of the form. This is basically feature of paperless, but is implemented for non paperless too				

12.3.5 Non-ART Follow up

Form No.	Form Label	Database Table	Field Name	Business Rule	Required for Saving	Minimum Reporting	Minimum Clinical
1	**First Name**	**mst_Patient**	FirstName	Auto filled	Yes	Yes	Yes
1	**Last Name**	**mst_Patient**	LastName	Auto filled	Yes	Yes	Yes
2	**Visit Date**	**ord_Visit**	VisitDate	Date on which the patient came into the clinic. The date cannot be same as pharmacy form. No future dates allowed - like 2020	Yes	Yes	Yes
3	**ID - Country**	**mst_Facility**	CountryID	Auto filled	Yes	Yes	
3	**ID - LOT#**	**mst_Facility**	PosID	Auto filled	Yes	Yes	
3	**ID - Satellite #**	**mst_Facility**	satelliteID	Auto filled	Yes	Yes	
3	**ID - Patient Enrollment Number**	**mst_Patient**	PatientEnrollmentID	Auto filled	Yes	Yes	
4	**Existing Hosp/Clinic #**	**mst_Patient**	PatientClinicID	Auto filled	Yes		Yes
6	**Last CD4 Count**	**dtl_PatientLabResult**	TestResults	Auto populate			
6	**Last CD4 Count Date**	**ord_PatientLabOrder**	ReportedbyDate	Auto populate			
9	**Pregnant**	**dtl_PatientClinicalStatus**	Pregnant	Should only display if the patient has Gender=female This should be defaulted to "No"		Yes	Yes
9	**LMP**	**dtl_PatientClinicalStatus**	LMP	LMP= Last Menstral Period Should only display if the patient has Gender=female			
	Presenting Complaints						
11	**Presenting Complaints**	**dtl_PatientSymptoms**	SymptomID	Default the UI to None; if other complaints are selected, None becomes de-selected.			
	Notes		Notes	Add free text fields in the follow up form for clinicians to type in their clinical notes			
TB Screening							
	Not Documented						
	Performed						
13	**Physical Exam**			**In this section, if the fields indicated below with "Yes" are not filled in, then in the database, the field should be noted as not documented. The UI**			

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				should give a warning error to the User.			
	Temp (Degrees C)	**dtl_PatientVitals**	Temp (deg C)	Field level validation boundaries: 30.0-50.0			
	RR (cam)	**dtl_PatientVitals**	RR	Field level validation boundaries: 4-100			
	HR (bum)	**dtl_PatientVitals**	HR	Field level validation boundaries: 30-200			
	BP Systolic (mm/ Hg)	**dtl_PatientVitals**	BPSystolic	Field level validation boundaries: 50-250			
	BP Diastolic (mm/ Hg)	**dtl_PatientVitals**	BPDiastolic	Field level validation boundaries: 30-150			
	Ht (cm)	**dtl_PatientVitals**	Height	Field level valdiation boundaries: 0-250 Auto populate from the IE form			Yes
	Wt (kg)	**dtl_PatientVitals**	Weight	Field level validation boundaries: 0-225			Yes
	Pain	**dtl_PatientVitals**	Pain	Pain is on a scale of 1 to 10.			
15	**HIV Associated Conditions/OIs or AIDs Defining Illness**						
	None, Pulmonary TB, Extrapulmonary TB, etc…	**dtl_PatientDisease**	Disease_pk, DiseaseName	The date for any check condition w ill be the visit date (as oppsed the the IE form w here the dates are explicitely given by the patient.)			Yes [none, conditions entered or not documented must be filled in]
16	**Assessment**						
	Clinical Assessment	**dtl_PatientAssessment**	AssessmentID	Note that these assessment types are different than on the IE form.	Yes		Yes
	ART Assessment - Re-evaluate; Prepare for ART	**dtl_PatientAssessment**	AssessmentID				
	WAB Stage	**dtl_PatientStage**	WABStage				Yes
	WHO Stage	**dtl_PatientStage**	WHOStage				Yes
17	**OI Prophylaxis and Treatment**						
	OI Prophylaxis - Sulfa/TMZ - Dose	**dtl_PatientPharmacyOrder**	Drug_Pk, StrengthID	Drugs can be selected w ithout selecting duration etc.Dose and frequency are the only required fields			
	OI Prophylaxis - Sulfa/TMZ - Frequency	**dtl_PatientPharmacyOrder**	FrequencyID	DS=Double Strength; SS = Single Strength			
	OI Prophylaxis - Sulfa/TMZ - Duration	**dtl_PatientPharmacyOrder**	Duration				
	OI Prophylaxis - Sulfa/TMZ - Quantity	**dtl_PatientPharmacyOrder**	OrderedQuantity				
	OI Prophylaxis - Sulfa/TMZ - Dispensed	**dtl_PatientPharmacyOrder**	DispensedQuantity				
	OI Prophylaxis - Fluconazole -	**dtl_PatientPharmacyOrder**	Drug_Pk, StrengthID				

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	Strength						
	OI Prophylaxis - Fluconazole - Frequency	**dtl_PatientPharmacyOrder**	FrequencyID				
	OI Prophylaxis - Fluconazole - Duration	**dtl_PatientPharmacyOrder**	Duration				
	OI Prophylaxis - Fluconazole - Quantity	**dtl_PatientPharmacyOrder**	OrderedQuantity				
	OI Prophylaxis - Fluconazole - Dispensed	**dtl_PatientPharmacyOrder**	DispensedQuantity				
	OI Prophylaxis Other - Name	**mst_Drug dtl_PatientPharmacyOrder**	DrugName				
	OI Prophylaxis Other - Strength	**dtl_PatientPharmacyOrder**	StrengthID				
	OI Prophylaxis Other - Frequency	**dtl_PatientPharmacyOrder**	FrequencyID				
	OI Prophylaxis Other - Duration	**dtl_PatientPharmacyOrder**	Duration				
	OI Prophylaxis Other - Quantity	**dtl_PatientPharmacyOrder**	OrderedQuantity				
	OI Prophylaxis Other - Dispensed	**dtl_PatientPharmacyOrder**	DispensedQuantity				
18/19	**OI Treatment and Other Medications**						
	OI - Other- Name	**mst_Drug dtl_PatientPharmacyOrder**	DrugName				
	OI - Strength	**dtl_PatientPharmacyOrder**	StrengthID				
	OI - Units	**Code/decode table**		Units, selected by the user for the "other" drug Units: mcg, mg, g, UI, %			
	OI - Frequency	**dtl_PatientPharmacyOrder**	FrequencyID				
	OI - Duration	**dtl_PatientPharmacyOrder**	Duration				
	OI - Quantity	**dtl_PatientPharmacyOrder**	OrderedQuantity				
	OI - Dispensed	**dtl_PatientPharmacyOrder**	DispensedQuantity				
	OI - AIDSRelief provided	**dtl_PatientPharmacyOrder**	Financed				
	Ordered by	**dtl_PatientPharmacyOrder**	Orderedby				
	Ordered by Date	**dtl_PatientPharmacyOrder**	OrderedbyDate				
	Dispensed by	**dtl_PatientPharmacyOrder**	DispensedBy		Yes	Yes	Yes
	Dispensed by Date	**dtl_PatientPharmacyOrder**	DespensedByDate	This is a key date for non paperless, For paperless order by date is key date, that will be used in reporting for anything found on a pharmacy form. This date = dtl_PatientArvTherapy::	Yes		

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				PrescribedARVStartDate if the patient is starting therapy. This is indicated in the IE or FU forms.			
	Signature	**dtl_PatientPharmacyOrder**	EmployeeID				
	Adherence Counsellor Signature	**dtl_PatientPharmacyOrder**	Signature				
	When is the patient's next appointment?	**Dtl_Patientappointment**	**Appdate**	This date is automatically calculated based on appointment period selected.			
	Next appointment date	**Dtl_patientappointment**	**Appdate**	The date can be entered directly. If a date is entered, then appPeriod is Null.			
	Appointment Reason	**Dtl_patientappointment**	**AppReason**	Reasons are “Follow up”; “Lab test”; and “Treatment Preparation”			
	Print		Print	This button is used to take hard copy of the form. This is basically feature of paperless, but is implemented for non paperless too			

12.3.6 ART Follow up

Form No.	Form Label	Database Table	Field Name	Business Rule	Required for Saving	Minimum Reporting	Minimum Clinical
1	**First Name**	**mst_Patient**	FirstName	Auto filled	Yes	Yes	Yes
1	**Last Name**	**mst_Patient**	LastName	Auto filled	Yes	Yes	Yes
2	**Visit Date**	**ord_Visit**	VisitDate	Date on which the patient came into the clinic. No future dates allowed - like 2020	Yes	Yes	Yes
3	**ID - Country**	**mst_Facility**	CountryID	Auto filled	Yes	Yes	
3	**ID - LPTF#**	**mst_Facility**	PosID	Auto filled	Yes	Yes	
3	**ID - Satellite #**	**mst_Facility**	satelliteID	Auto filled	Yes	Yes	
3	**ID - Patient Enrollment Number**	**mst_Patient**	PatientEnrollmentID	Auto filled	Yes	Yes	
4	**Existing Hosp/Clinic #**	**mst_Patient**	PatientClinicID	Auto filled	Yes		Yes
6	**Last CD4 Count**	**dtl_PatientLabResult**	TestResults	Auto populate			
6	**Last CD4 Count Date**	**ord_PatientLabOrder**	ReportedbyDate	Auto populate			
6a	**CD4 prior to starting ARV**	**dtl_PatientHivPrevCareIE**	PriorARVsCD4	Non-editable, auto populated field from the IE form. Manual updates must be done via the IE form.			
6a	**CD4 prior to starting ARV Date**	**dtl_PatientHivPrevCareIE**	PriorARVsCD4Date	Auto populate from the IE form, OR fill in manually; the manually updated data should update the IE form field.			
7	**Last Viral Load**	**dtl_PatientLabResult**	TestResults	Auto populate			
7	**Last Viral Load Date**	**ord_PatientLabOrder**	OrderedbyName	Auto populate			

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8a	**Current Regimen Began**	**dtl_PatientArvTherapy**	PrescribedARVStartDate	Auto populate Date started or changed to new regimen; Check for the latest date (and associated regimen) 1) check the last FU form for the latest ARV regimen started or changed - and then use the DispensedByDate for the date; use the compilation of the ARVs as the Regimen 2) if there isn't a FU form, then check the IE form started or changed - and then use the DispensedByDate for the date; use the compilation of the ARVs as the Regimen			
8b	**Regimen (Current)**	**dtl_RegimenMap**	RegimenType	Auto populate- the information is coming from the adult or pedi pharmacy form and should reside in the regimen map table Note the format of the Regimen is AAA/BBB/CCC - use of forward slashes between the abbreviations			
9	**Pregnant**	**dtl_PatientClinicalStatus**	Pregnant	Should only display if the patient has Gender=female This should be defaulted to "No"		Yes	Yes
9	**LMP**	**dtl_PatientClinicalStatus**	LMP	LMP= Last Menstral Period Should only display if the patient has Gender=female			
	Adherence						
10	**Number of doses missed last week**	**dtl_PatientAdherence**	MissedLastWeek	If None checked, then MissedLastWeek= 0 and the UI should be blanked out or hidden Add not documented botton for the Number of doses missed last week and/or last month - if nothing is in the form for either of these items, the data entry person will be able to check that is was not documented.			Yes or check "None"
10	**Number of doses missed last month**	**dtl_PatientAdherence**	MissedLastMonth	If None checked, then MissedLastMonthe= 0 and the UI should be blanked out or hidden			
10	**Number of DOT times/week**	**dtl_PatientAdherence**	NumDOTPerWeek				
10	**Number of Home visits times/week**	**dtl_PatientAdherence**	NumHomeVisitsPerWeek				
10	**Support group**	**dtl_PatientAdherence**	SupportGroup				
10	**Rx was interrupted (unintentional)**	**dtl_PatientAdherence**	Interrupted				
10	**Rx interrupted date**	**dtl_PatientAdherence**	InterruptedDate	Only one of RX interrupted or RX stopped can be selected.			
10	**Number of days Rx interrupted**	**dtl_PatientAdherence**	InterruptedNumDays				
	Rx was stopped (intentional)	**dtl_PatientAdherence**	StoppedNumDays				
	Rx stopped date	**dtl_PatientAdherence**	StoppedDate				
	Reason Missed	**dtl_PatientAdherence**	MissedReason	One of the Adherence codes; More than one can apply.			
10	**Reason Missed Other**	**dtl_PatientAdherence**	MissedReasonOther				
10	**Patient reports taking herbal medications**	**dtl_PatientAdherence**	HerbalMeds				
	Presenting Complaints						
11	**Presenting Complaints**	**dtl_PatientSymptoms**	SymptomID	Default the UI to None; if other complaints are selected, None becomes de-selected.			
TB Screening							
	Not documented						

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	Performed						
13	**Physical Exam**						
	Temp (Degrees C)	**dtl_PatientVitals**	Temp (deg C)	Field level validation boundaries: 30.0-50.0			
	RR (cam)	**dtl_PatientVitals**	RR	Field level validation boundaries: 4-100			
	HR (bum)	**dtl_PatientVitals**	HR	Field level validation boundaries: 30-200			
	BP Systolic (mm/ Hg)	**dtl_PatientVitals**	BPSystolic	Field level validation boundaries: 50-250			
	BP Diastolic (mm/ Hg)	**dtl_PatientVitals**	BPDiastolic	Field level validation boundaries: 30-150			
	Ht (cm)	**dtl_PatientVitals**	Height	Field level valdiation boundaries: 0-250 Auto populate from the IE form			Yes
	Wt (kg)	**dtl_PatientVitals**	Weight	Field level validation boundaries: 0-225			Yes
	Pain	**dtl_PatientVitals**	Pain	Pain is on a scale of 1 to 10.			
14	**ARV Side Effects**						
	Non, Recent weight loss, fever, etc...	**dtl_PatientSymptoms**	SymptomID	Default the UI to None; Not documented button is available if other complaints are selected, None becomes de-selected. mst_SymptomCategory = ARV Side Effect			Yes [none, conditions entered or not documented must be filled in]
15	**HIV Associated Conditions/OIs or AIDs Defining Illness**						
	None, Pulmonary TB, Extrapulmonary TB, etc...	**dtl_PatientDisease**	Disease_pk, DiseaseName	The date for any checked condition will be the visit date (as opposed the the IE form where the dates are explicitely given by the patient.)			Yes [none, conditions entered or not documented must be filled in]
16	**Assessment**						
	Clinical Assessment	**dtl_PatientAssessment**	AssessmentID	Note that these assessment types are different than on the IE form.			Yes
	WAB Stage	**dtl_PatientStage**	WABStage				Yes
	WHO Stage	**dtl_PatientStage**	WHOStage				Yes
17	**ARV Therapy**						
	Treatment not indicated now	**dtl_PatientArvTherapy**	TherapyPlan	For non-paperless, this is a required field; For paperless, this is not a requied field.	Yes, for non-paperless		Yes, for non-paperless
	Continue Current	**dtl_PatientArvTherapy**	TherapyPlan				
	Restart Treatment	**dtl_PatientArvTherapy**	TherapyPlan				
	Start New Treatment	**dtl_PatientArvTherapy**	TherapyPlan				

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	Change regimen reason code	**dtl_PatientArvTherapy**	TherapyReasonCode	If currARVTherapy=Change treatment then TherapyReasonCode is required			
	Stop regimen reason code	**dtl_PatientArvTherapy**	TherapyReasonCode	If currARVTherapy=Stop treatment then TherapyReasonCode is required			
	Notes		Notes	Free text field in the follow up form for clinicians to type in their clinical notes			
18	**Appointment Scheduling**						
	When is the patient's next appointment?	**Dtl_Patientappointment**	**Appdate**	This needs to be tied into the schedule. The date should be automatically calculated based on appointment period.			
	Next appointment date	**Dtl_patientappointment**	**Appdate**	The date can be entered directly. If a date is entered, then appPeriod is Null.	Yes		
	Appointment Reason	**Dtl_patientappointment**	**AppReason**	This is a new field: reasons are “Follow up”; “Lab test”; and “Treatment Preparation”			
19	**Signature**	**dtl_PatientClinicalStatus**	signiture				
	Print		Print	This button is used to take hard copy of the form. This is basically feature of paperless, but is implemented for non paperless too			

12.3.7 Care Ended

Database Table	Field Name	Business Rule	Required for Saving	Minimum Reporting	Minimum Clinical
mst_Patient	FirstName	Auto filled	Yes	Yes	Yes
mst_Patient	LastName	Auto filled	Yes	Yes	Yes
mst_Patient	PatientEnrollmentID	Auto filled	Yes	Yes	
mst_Patient	PatientClinicID	Auto filled	Yes		Yes
dtl_PatientCareEnded	MissedAppDate	Auto filled: Last appointment where AppStatus=Missed			Yes
dtl_PatientTrackingCare	DateLastContact	Auto filled but editable Check the latest date from the latest Enrollment/IE/FU visit date; Adult/ Pediatric pharmacy DispensedByDate; Laboratory RepotedByDate; Home Visit last date for which the patient data was captured When you view forms - the label should be as follows: Situation-care ended=no Care Tracking (date of last actual contact)	To save a form with care ended=no, you must fill in the "Date of last actual contact".		Yes
dtl_PatientCareEnded	PatientExitReason	Options: Lost to follow up, Transfer to another LPTF, Death		Yes If Care Ended = Yes, One reason must be selected	Yes if Patient Care Ended = Yes
dtl_PatientCareEnded	EmployeeID				

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dtl_PatientCareEnded	CareEndedSignatureDate	Care ended date must be greater than last contact date	To save a form with care ended=yes, you must fill in the "Care ended date	Yes	Yes if Patient Care Ended = Yes
	Print	This button is used to take hard copy of the form. This is basically feature of paperless, but is implemented for non paperless too			

12.3.8 Home Visit

Home Visit Form Business Rules						
Form Label	Database Table	Field Name	Business Rule	Required for Saving	Minimum Reporting	Minimum Clinical
First Name	mst_Patient	FirstName	Auto filled	Yes	Yes	Yes
Last Name	mst_Patient	LastName	Auto filled	Yes	Yes	Yes
ID - Country	mst_Facility	CountryID	Auto filled	Yes	Yes	
ID - LPTF#	mst_Facility	PosID	Auto filled	Yes	Yes	
ID - Satellite #	mst_Facility	satelliteID	Auto filled	Yes	Yes	
ID - Patient Enrollment Number	mst_Patient	PatientEnrollmentID	Auto filled	Yes	Yes	
Existing Hosp/ Clinic #	mst_Patient	PatientClinicID	Auto filled	Yes		Yes
CHW/CHV/ Nurse Team						
Alternative CHW/ CHV Team						
Visit start date				Yes		
Number of visits per week						
Number of weeks			We might consider doing something fancy with the UI here - such as only displaying the appropriate number of lines for the number of days visted per			

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			week.			
Number of days visited in week 1		Need new fields for this data	Need new fields for this data			
Number of days visited in week 2		Need new fields for this data	Need new fields for this data			
Number of days visited in week 3		Need new fields for this data	Need new fields for this data			
Number of days visited in week 4		Need new fields for this data	Need new fields for this data			
Print		Print	This button is used to take hard copy of the form. This is basically feature of paperless, but is implemented for non paperless too			

12.4 Uganda Blue Card Data Dictrionary

The Uganda Blue Card form set includes the following static forms. The data dictionaries and business rules can be found in this section.

- Prior ART HIV Care
- ART Care
- HIV Care/ART Encounter
- Exposed Infant

12.4.1 Prior ART HIV Care

Form Label	Data Entry Type	Business Rules	IQCare Table	IQCare Field
Section: Prior ART				
Prior ART	Radio button [Yes, No]	if prior ART is Yes - then display the remaining fields in this section. Required	dtl_PriorArvAndHivCare	PriorART
PEP	Check box	If PEP check box check, display the remaining fields	dtl_PriorArvAndHivCare	PEP
Start Date	Date		dtl_PatientPriorART	PEPStartDate
Where	Text box		dtl_PatientPriorART	~~PEPWhere~~
ARVs	Text	Use Regimen picker	dtl_PatientPriorART	PEPARVs

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PMTCT Only	Check box	If PMTCT Only check box check, display the remaining fields	dtl_PMTCTDetails	PMTCTOnly
Start Date	Date		dtl_PMTCTDetails	PMTCTStartDate
Where	Text box		dtl_PMTCTDetails	PMTCTWhere
ARVs	Text	Use Regimen picker	dtl_PMTCTDetails	PMTCTARVs
Earlier ARV not transfer	Check box	If Earlier ARV not transfer check box check, display the remaining fields	dtl_PriorArvAndHivCare	
Start Date	Date		dtl_PriorArvAndHivCare	
Where	Text box		dtl_PriorArvAndHivCare	
ARVs	Text	Use Regimin picker	dtl_PriorArvAndHivCare	
Section: HIV Care				
Date Confirmed HIV Positive	Date	Data Quality Check	dtl_PatientHivPrevCareEnrollment	ConfirmHIVPosDate
Test Type	Select list [Ab, PCR]	Display select list only if age is <= 18 months	dtl_PriorArvAndHivCare	HivTestType
Where	Text box		dtl_PriorArvAndHivCare	
HIV Care transfer in from	Text box			
Date Eligible for ART	Date		dtl_PatientARVInfo	EligibleDate
Clinical Stage	Select List [1,2,3,4, T1, T2, T3, T4, NA]	WHO Stage No business rule for WHO stage - no need to force the last selected stage.	dtl_PatientStage	WHOStage
CD4 Count	Integer		dtl_PatientHivPrevCareIE	PrevARVsCD4
CD4 %	Integer		dtl_PatientHivPrevCareIE	PrevARVsCD4Percent
Eligible and Ready	Date		dtl_PatientARVInfo	ReadyDate
Presumptive HIV diagnosis	Check box			
PCR-infant	Check box			
Section: Drug Allergies and Relevant Medical Conditions				
Drug Allergies	Text		dtl_DrugAllegiesAndMedicalCondition	DrugAllergySpecify
Type of reaction	Text box		dtl_DrugAllegiesAndMedicalCondition	TypeOfReaction
Date of allergy	Date		dtl_DrugAllegiesAndMedicalCondition	DateOfAllergy
Relevant Medical Conditions	Multi-line text		dtl_DrugAllegiesAndMedicalCondition	RelevantMedicalConditions

12.4.2 ART Care

Form Label	Data Entry Type	Business Rules	IQCare Table	IQCare Field

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Cohort Month	Text	Text display To Be calculated based on the Month and year from the - Historical ART Start Date OR the ART Start Date at this Facility	dtl_PatientHivPrevCareIE	CohortMonth
Cohort Year	Integer	Text display To Be calculated based on the Month and year from the - Historical ART Start Date OR the ART Start Date at this Facility	dtl_PatientHivPrevCareIE	CohortYear
Section: Transfer in on ART				
ART Transfer in Date	Date	This is the historical ART Start Date	dtl_PatientHivPrevCareIE	ARTTransferInDate
ART Transfer in from	Select-list		dtl_PatientHivPrevCareIE	LPTFTransfer
Transfer in ARVs	Regimen list		dtl_PatientHivPrevCareIE	PrevARVRegimen
ART Start at Another Facility				
Start ART 1st Line Regimen Date	Date		Dtl_PatientARTCare	FirstLineRegStDate
Regimen	Text box	Use Regimen picker	Dtl_PatientARTCare	FirstLineReg
Weight (Kgs)	Decimal		dtl_PatientVitals	Weight
Clinical Stage	Select List [1,2,3,4]		dtl_PatientStage	WHOStage
CD4	Integer		Dtl_PatientARTCare	CD4
CD4 %	Integer		Dtl_PatientARTCare	CD4Percent
Pregnant	Select list [Preg=Pregnant, PP=Postpartum, No]		Dtl_PatientARTCare	Pregnant
ART Start at This Facility (Auto populated fields from HIV Encounter, pharmacy, Lab)				
Start ART 1st Line Regimen Date	Date	System takes the first Pharamacy Dispensed Date where ARV Medications are dispensed with First Line regimen selected from Regimen Line dropdown.	mst_patient	ART Start Date

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		Program should be "ART"		
Regimen	Text	System takes the first Pharamacy Dispense Regimen with Line as "First Line" and Program as "ART".	dtl_RegimenMap	Regimentype
Weight (Kgs)	Decimal	Weight on the visit closest to when ARVs were dispensed.	dtl_PatientVitals	Weight
Clinical Stage	Select List [1,2,3,4, T1, T2, T3, T4, NA]	Clinical Stage on the visit closest to when ARVs were dispensed.	dtl_PatientStage	WHOStage
CD4	Integer	Lab closest to when ARVs were dispensed.	dtl_PatientLabResults	TestResults
CD4 %	Integer	Lab closest to when ARVs were dispensed.	dtl_PatientLabResults	TestResults
Pregnant	Select list [Preg=Pregnant, PP=Postpartum, No]	Pregnancy on the visit closest to when ARVs were dispensed.	New Field	
Substitutions and Switches (Auto populated grid view) - all fields auto populated				
Date1..n			ord_PatientPharmacyOrder	DispensedByDate
Regimen1..n			dtl_RegimenMap	Regimentype
Line			ord_PatientPharmacyOrder	Regimenline
Why 1..n			dtl_PatientArvTherapy	TherapyReasonCode
ART Treatment Interruptions	**4 entries available**			
Stop/Lost 1..n				
Date 1..n				
Why 1..n				

12.4.3 HIV Care/ART Encounter

Field Label	Display Type	Business Rule	Table Name	Column Name
Visit Date	Date		Ord_Visit	VisitDate

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If Scheduled	Checkbox		Dtl_PatientARTEncounter	Scheduled
TreatmentSupportName	Text box		Dtl_PatientARTEncounter	SupporterName
TreatmentSupportContact	Text box		Dtl_PatientARTEncounter	TreamentSupporterContact
FollowUpDate	Date		Dtl_PatientAppointment	AppDate
Duration in months since starting ART		Calculated field. The lesser of (Visit Date or ART ended date) minus (Historical ART Start date OR the ART Started at this facility date)		
Duration in months since starting current regimen		Calculated field. The lesser of (Visit Date or ART ended date) minus (first dispensed by date of the current regimen)		
Clincal Status				
Weight	Text box		Dtl_PatientVitals	Weight
Height	Text box		Dtl_PatientVitals	Height
Oedema	Radio	Enable when stictly less than 60 months of age	Dtl_PatientVitals	Oedema
Pregnant	Radio	Display for females only; When patient is less than or equal to 12 years old the options will be disabled.	Dtl_PatientClinicalStatus	Pregnant
EDD	Date	Display for females only <=12 year disable	Dtl_PatientClinicalStatus	EDD
Gestation	Text box	Display for females only <=12 year disable	Dtl_PatientDelivery	GestAge
PMTCT	Checkbox	Display for females only <=12 year	Dtl_PatientClinicalStatus	PMTCT

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		disable		
PMTCT/ANC No.	Text box	Display for females only <=12 year disable Save in Mst_Patient table only when ANCNumber column is null or blank. Should be autopopulated, in case of existing data.	Mst_Patient	ANCNumber
DeliveryDate	Date	Save/Update according to user Input	Dtl_PatientClinicalStatus	DateofDelivery
Post Partum		Display for females only <=12 year disable Calculated Field. Check if the Patient has delivered (Delivery Date is filled.)	No table	No Field
Family Planning	Select list	When patient is less than or equal to 12 years old the options will be disabled.	Dtl_PatientCounseling	FamilyPlanningStatus
Family Planning Methods	Multi select list	Display only if FP is "On Family Planning" is selected When patient is less than or equal to 12 years old the options will be disabled.	Dtl_PatientFamilyPlanning	FamilyPlanningMethod

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MUAC	Text box	Should be Visible if patient age is less or equal to than 60 months; Display in months	Dtl_PatientClinicalStatus	MUAC
Age		Calculated. Visitdate - Date of Birth (Months) with decimal displayed to one digit Should be Visible if patient age is less or equal to than 60 months	No table	No Field
TBStatus	Select list		Dtl_PatientOtherTreatment	TBStatus
TB RX Start	Date	Display if TB Rx selected. Date should be greater than patient DOB	Dtl_PatientOtherTreatment	TBRxStartDate
TB RX Stop	Date	Display if TB Rx selected. Date should not be less than RX Start Date	Dtl_PatientOtherTreatment	TBRxEndDate
TB Reg #	Text box	Display if TB Rx selected.		
Potential Side Effects	Multi select list		Dtl_PatientSymptoms	Symptomid
Potential Side Effects Other	Text box			
New OI, Other Problems	Multi select list		Dtl_PatientDisease	Disease_Pk
New OI Other	Text box			
Nutritional Problem	Select list	Display this field only when patient	Dtl_PatientARTEncounter	NutritionalProblem

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		age is below 60 months. Mst_Nutritionalproblem		
WAB Stage	Select list		Dtl_PatientStage	WABStage
WHO Stage	Select list	Select list options: NA, 1, 2, 3, 4, T1, T2, T3, T4	Dtl_PatientStage	WHOStage
Pharmacy				
Pharmacy	Button	Open Adult/Peadeatric Pharmacy form according to Age of the patient		
CPT Adherence-Adhere	Select list		Dtl_Adherence_Reason	Cotrimoxazole Adherence
ARV Adherence - Adhere	Select list		Dtl_PatientAdherence	ARVAdhere
ARV Adherence - Why Poor/Fair	Select list	Display if fair or poor selected	Dtl_PatientAdherence	ARVAdhereceReason
ARV Adherence - Other	Text box	Only enabled when Other is selected in Why Poor/Fair Option	Dtl_PatientAdherence	AdherenceReasonOther
Substitution-Interuption	Select list	Required field	Dtl_PatientARVTherapy	TherapyPlan
Substitution-Interuption - Change Reason	Select list If Changed: Select list [1=Toxicity/ Side effects, 2=Pregnancy, 3=Risk of pregnancy, 4=Due to new TB, 5=New drug available, 6=Drug out of stock, 7=Other reasons (specify)] If Stopped: Select list	Required field if Change, Stopped selected	Dtl_PatientARVTherapy	TherapyReasonCode

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	[1=Toxicity/ Side effects, 2=Pregnancy, 3=Risk of pregnancy, 4=Due to new TB, 5=New drug available, 6=Drug out of stock, 7=Other reasons (specify), 8=Clinical treatment failure, 9=Immunologic failure]			
Investigations				
Laboratory-Investigation	Button	Open Laboratory Form		
Referrals and Consultations				
Referred To	Multi select list		Dtl_PatientReferredTo	PatientRefId
Referred To-Other	Text box	Only enabled when Other is selected in Referred To Option	Dtl_PatientReferredTo	PatientRefDesc
No of Days Hospitalized	Text box		Dtl_PatientCounseling	HospitalizedNumberofDays
Nutritional Support	Select list		Dtl_PatientCounseling	NutritionalSupport
Infant Feeding Practice	Select list	Enable if the patient is < 2 years OR Female and >12 years	Dtl_InfantInfo	FeedingOption
AttendingClinician			Dtl_PatientARTEncounter	AttendingClinician

.

12.4.4 Exposed Infant

Form Label	Data Entry Type	Business Rules	IQCare Table	IQCare Field
Infant Name: First	Text	Required	dtl_ExposedInfant,	FirstName

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			varchar	
Infant Name: Last	Text	Required	dtl_ExposedInfant, varchar	LastName
Infant No.	Text	This is not necessarily a unique number.	dtl_ExposedInfant, int	ExposedInfantId
DOB	Date	Required	dtl_ExposedInfant, datetime	DOB
Infant Feeding Practice at 3 months	Select list [Exclusive Breast Feeding, Replacement Feeding, Mixed Feeding]		dtl_ExposedInfant, varchar	FeedingPractice3mos
CTX Started by 2 Months	Select list [Yes, No]		dtl_ExposedInfant, varchar	CTX2mos
HIV Test Type	Select list [AB, PCR]		dtl_ExposedInfant, varchar	HIVTestType
HIV test result	Select list [Pos, Neg]		dtl_ExposedInfant, varchar	HIVResult
Final Status	Select list [D=Dead, P=Positive, N=Negative, N/BF=Negative and still breast feeding, U = Unknown]		dtl_ExposedInfant, varchar	FinalStatus
Death Date		If Death, then display the death date.	dtl_ExposedInfant, datetime	DeathDate

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